

**SHORT-DOYLE/MEDI-CAL
ORGANIZATIONAL PROVIDER'S MANUAL**
for
SPECIALTY MENTAL HEALTH SERVICES
under
THE REHABILITATION OPTION
and
TARGETED CASE MANAGEMENT SERVICES

Children/Adolescents,
Transitional Age Youth (TAY),
Adults and Older Adults

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**LOS ANGELES COUNTY
LOCAL MENTAL HEALTH PLAN**



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TABLE OF CONTENTS

CHAPTERS	PAGE(S)	LAST UPDATE
Chapter 1: Service, Documentation, and Reimbursement Basics		
General Service and Reimbursement Rules		
Overview	5	6/12/14
Service Philosophy	6	6/12/14
Medi-Cal Reimbursement Rules	6	11/21/14
General Documentation Rules	10	6/12/14
Medi-Cal Medical Necessity		
Description	11	6/17/15
Medical Necessity Criteria	12	10/1/15
Documentation for Medical Necessity: The Clinical Loop	13	6/12/14
The Clinical Loop	14	6/12/14
Assessment		
Description	14	6/12/14
New Client Assessment	15	10/1/15
Returning Client Assessment	17	10/1/15
Continuous Client Assessment	18	10/1/15
Assessment Addendum	19	6/12/14
Client Treatment Plan		
Description	20	6/12/14
Annual Client Treatment Plan	21	6/12/14
Update Client Treatment Plan	22	6/12/14
Additional Information	23	6/12/14
Progress Notes		
Description	24	6/12/14
Progress Notes	24	6/17/15
Service Components		
Definition	26	11/21/14
Service Components	26	6/1/15
Chapter 2: Services Based on Minutes of Staff Time (Mode 15)		
Service Overview and Reimbursement Rules		
General Rules	32	6/12/14
Documentation Rules	32	6/12/14
Types of Services		
Mental Health Services	34	6/12/14
Medication Support Services	36	12/18/15
Crisis Intervention	38	6/12/14
Targeted Case Management	39	6/1/15
Therapeutic Behavioral Services (TBS)	40	6/1/15

Chapter 3: Services Based on Blocks of Time (Mode 10)

Service Overview & Reimbursement Rules

General Rules	47	11/21/14
Crisis Stabilization Services (CS)	47	11/21/14
Day Treatment Intensive (DTI)	49	11/21/14
Day Rehabilitation (DR)	54	11/21/14
Socialization Day Services	58	11/21/14
Vocational Services	59	11/21/14

Chapter 5: Services Based on Calendar Days

General Rules
Adult Residential Services (Transitional and Long-Term)
Crisis Residential Treatment Services
Psychiatric Health Facility

Chapter 6: Definitions

Definitions

Appendix

Chapter 1

Website Addresses		
Examples of Medi-Cal Reimbursable and Non-Reimbursable Activities		
Progress Note Samples		
Medi-Cal Included Diagnoses	A-1	12/18/15

CHAPTER 1

Service, Documentation, and Reimbursement Basics

GENERAL SERVICE AND REIMBURSEMENT RULES

MEDI-CAL MEDICAL NECESSITY – THE CLINICAL LOOP

ASSESSMENT

CLIENT TREATMENT PLAN

PROGRESS NOTES

SERVICE COMPONENTS

GENERAL SERVICE AND REIMBURSEMENT RULES

OVERVIEW

With the federal approval of the Medi-Cal Specialty Mental Health Services Consolidation waiver program on September 5, 1997, the State Department of Mental Health (now the State Department of Health Care Services [State DHCS]) implemented standardized regulations with the adoption of Chapter 11, *Medi-Cal Specialty Mental Health Services*, in Division 1 of Title 9, California Code of Regulations (CCR). This modified some of the rules under which mental health services are provided and claims for reimbursement are made.

This manual reflects the current requirements for direct services reimbursed by Medi-Cal and serves as the basis for all documentation and claiming in the Los Angeles County Department of Mental Health (LACDMH) regardless of payer source. Per LACDMH Policy 401.03, all providers, whether Directly-Operated or Contracted, must abide by the information found in this manual. Information referenced in this manual incorporates requirements from the following key sources:

- Code of Federal Regulations (CFR);
- California Code of Regulations (CCR);
- State Plan Amendments (SPA);
- State DHCS Contract with LACDMH (State Contract);
- State DHCS Letters and Information Notices;
- DHCS Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) and Therapeutic Foster Care (TFC) for Katie A Subclass Members (DHCS Katie A Manual);
- LACDMH Policy and Procedure;
- LACDMH Requirements.

Additional sources may be cited throughout the manual. The symbol "§" placed in the reference denotes "Section" and is followed by the associated regulation's numerical code. All references to a regulatory section from California Code of Regulations are from Title 9, Chapter 11 unless otherwise specified. See the Appendix for further description and explanation of the above referenced sources.

The Quality Assurance Division issues Quality Assurance (QA) Bulletins as a way of communicating updates or clarifications to information found in this Manual. QA Bulletins are considered to be official LACDMH requirements and will be incorporated into this Manual as appropriate.

Some funded programs that are not funded by Medi-Cal may allow for reimbursement of services that do not meet the requirements as set forth in this document. Refer to the "Guidelines for Claiming by Funded Program" for additional information on claiming and reimbursement by funded program.

Chapters 2, 4, and 5 include the definitions for Consolidated Medi-Cal services that are reimbursable under the federal Rehabilitation Option and Targeted Case Management. Besides providing the definition of the service, other clarifying information such as service activities, documentation requirements, minimum staffing requirements, billing unit, site and contact requirements, and lockouts (prohibitions on claiming to Medi-Cal for specific services in specific situations) are included.

SERVICE PHILOSOPHY

Medi-Cal services provided under the federal Rehabilitation Option focus on client needs, strengths, choices and involvement in treatment planning and implementation. The goal is to help clients take charge of their lives through informed decision-making. Services are based on the client's long-term goals/desired result(s) from mental health services concerning his/her own life and his/her diagnosis, functional impairment(s), symptoms, disabilities, life conditions and rehabilitation readiness. Services are focused on achieving specific, measurable objectives to support the client in accomplishing his/her desired results. Program staffing is multi-disciplinary and reflects the cultural, linguistic, ethnic, age, gender, sexual orientation and other social characteristics of the community that the program serves. Families, caregivers, human service agency personnel and other significant support person are encouraged to participate in the planning and implementation process in meeting the client's needs, choices, responsibilities and desires. Programs are designed to use both licensed and non-licensed personnel who are experienced in providing services in the mental health field.

MEDI-CAL REIMBURSEMENT RULES

Key Points Applicable to One or More Mode of Services

- **A Provider must either be certified as a Mental Health Rehabilitation Provider (CCR §1810.435) or licensed** by State Department of Health Services (DHS) as a Psychiatric Hospital Service, Inpatient Hospital Service, or Outpatient Hospital Service to be eligible for reimbursement for providing Medi-Cal services. See the Certification Guidelines at: http://psbqi.dmh.lacounty.gov/QA_MediCal.htm
- **Hospital outpatient departments** as defined in Title 22, CCR §51112, operating under the license of a hospital **may only provide services in compliance with licensing requirements.**
- **Every claim must be supported by a progress note that must be present in the clinical record prior to the submission of the claim (State Contract).**

- **All covered services must be provided under the direction (CCR §1840.314) of an Authorized Mental Health Discipline (AMHD) and as designated by the Program Manager:** Examples of service direction include, but are not limited to:
 - Being the person providing the service;
 - Acting as a clinical team leader;
 - Direct or functional supervision of service delivery; or
 - Approval of Client Care Plans.

The person providing direction is not required to be physically present at the service site to exercise direction (State DMH Letter No.: 01-02).

NOTE: Authorized Mental Health Disciplines include the following:

1. Licensed Psychiatrist/Physician, (MD/DO);
2. Certified Nurse Practitioner (NP), registered Clinical Nurse Specialist (CNS), Registered Nurse (RN);
3. Licensed or waived Psychologist (PhD/PsyD);
4. Licensed Clinical Social Worker (LCSW) or registered Masters in Social Work (Associate Clinical Social Worker - ASW) or out-of-state licensed-ready waived Masters in Social Work;
5. Licensed Marriage and Family Therapist (LMFT) or registered Marriage and Family Therapist (MFT Intern) or out-of-state licensed-ready waived Marriage and Family Therapist;
6. Licensed Professional Clinical Counselor (LPCC) or registered Professional Clinical Counselor (PCC) and
7. All students of these disciplines with co-signature signifying final responsibility lies with the co-signer (a formal written agreement between the school and the Legal Entity must be in place for staff to be considered a student).

- **Services shall be provided within the scope of practice of the person delivering the service, if professional licensure is required for the service (CCR §1840.314), and his/her employer's job description/responsibility.** The local mental health director shall be responsible for assuring that services provided are commensurate with the professionalism and experience of the staff utilized.
- **Services provided after the death of a client may not be claimed to Medi-Cal.**
- **Services should be provided in the setting and manner most appropriate to the treatment and service needs of the client (State DMH Letter No.: 02-07).**
- **The time required for documentation and travel must be linked to the delivery of the reimbursable service (CCR §1840.316).** The time required for documentation and travel is reimbursable when the documentation or travel is a component of a reimbursable service whether or not the time is on the same day as the reimbursable service. If documentation or travel occurs on a day other than the date of the service, the Progress Note must still be dated the date of the service and must include the documentation and/or travel time on that date. There must be a reference in the note of when the documentation/travel time occurred if on a different date than the date of service. While, on occasion, this may result in the claimed hours on a particular day exceeding the actual hours worked, this is not an audit issue as long as the total time claimed accurately reflects the service/travel/documentation time provided and when it occurred.

- **As with all Medi-Cal services, travel should be individualized to the needs of the client.** Travel time should be reasonable and appropriate given normal circumstances. If travel time is extensive, the note should document distance traveled to support the claim.
- **Travel time between two provider sites (i.e. two billing providers) is not reimbursable.** (SMART FAQ) Travel time may only be claimed from a provider site to an off-site location. Provider sites include satellites and school site operations.
- **Transportation services are not reimbursable** (CCR §1810.355).
- **Missed Appointments (and no services provided) are not reimbursable** (State DMH Letter No.: 02-07). This includes missed appointments at the provider's site, the client's home, or elsewhere in the community. While documenting a missed appointment or a voice mail/telephone message for a client is important, this time or travel time to a missed appointment cannot be claimed when no services are provided.
- **Services are non-reimbursable by Medi-Cal when:**
 - Provided in a jail or prison setting (Title 22, CCR §50273).
 - Provided to persons aged 22 through 64 who are residents of an Institution for Mental Disease (IMD) (CCR §1840.312). An IMD is defined as a hospital nursing facility, or other institution that has minimally more than 16 beds and is primarily engaged in providing diagnosis, treatment or care of persons with mental illness, including medical attention, and related services (CCR §1810.222.1); (Title 42, CFR, CCR §435.1009). As such, a free standing Psychiatric Hospital or a State Hospital qualifies as an IMD.
 - A client under 21 years of age resides in an IMD other than a Psychiatric Health Facility (PHF) that is a hospital or an acute psychiatric hospital, **except** if the client under 21 years of age was receiving such services prior to his/her 21st birthday. If this client continues without interruption to require and receive such services, the eligibility for Federal Financial Participation (FFP) dollars continues to the date he/she no longer requires such services, or if earlier, his/her 22nd birthday.
 - Lock-out rules apply that appear in Chapter subsections of this Manual and restrict conditions of a claim.
- **Services provided to children or adolescents in a juvenile hall setting are only reimbursable when the minor has been adjudicated and is awaiting suitable placement** (Title 22 CCR §50273 and State DHCS Letter No. 12-2). Judicial legal orders from the court must be issued and indicate that the continuing detention in the juvenile hall setting is for the safety and protection of the minor based on criteria outlined in [WIC, Section 628]; i.e., the minor is **not** being detained for reasons related to arrest or violation of probation.

- **Services of clerical support personnel are not reimbursable** (CCR §1830.205). While it may be appropriate at times to record in the clinical record activities or observations of these personnel, their cost are included in overhead rates, for which the Department receives a percent of Medi-Cal reimbursement.
- **Clerical activities performed by any staff are not reimbursable.** While it is important to document in the clinical record when information is faxed or mailed, these activities are clerical and are not reimbursable. They should be documented in a separate note from the reimbursable service identifying that no time was claimed for these activities.
- **Supervision time is not reimbursable.** Supervision focuses on the supervisee's clinical/educational growth (as when meeting to monitor his/her caseload or his/her understanding of the therapeutic process) and is **NOT** reimbursable time. Supervision time required by Department policy or State licensing boards always falls within this definition and, thus, is never reimbursable. If a contact between a supervisor and supervisee does not fall within these definitions, but focuses instead on client needs/planning, the time is **not** considered supervision and **may** be claimed.
- **Personal care services performed for the client are not reimbursable** (State DMH Letter No.: 01-01). Examples include grooming, personal hygiene, assisting with medication, child or respite care, housekeeping, and the preparation of meals.
- **Conservatorship investigations are not reimbursable.**
- **Payee related services are not reimbursable** (CCR §1840.312).
- **Vocational, Educational, Recreational, and Socialization Activities are not reimbursable** (CCR §1840.312). Activities which focus on skills specific to vocational training, academic education, recreation, or socialization activity are **not** reimbursable. Hence, Socialization is not reimbursable if the activities consist of generalized group activities that do not provide systematic individualized feedback to specific targeted behaviors of the clients involved. Similarly, Vocational services for the purpose of actual work or work training, whether or not the client is receiving wages, is not reimbursable by Medi-Cal. **However**, when the activities are used to achieve a therapeutic goal, the mental health service that was provided should be documented and is reimbursable by many payers. Reimbursable services can be delivered at a work, academic, or recreational site; as long as the interventions focus on aiding the client to integrate into the community, access necessary resources, or maximize interpersonal skills. Please see Appendix item, "Examples of Medi-Cal Reimbursable and Non-Reimbursable Vocational, Educational, Recreational, and Socialization Activities".
- **Translation or interpretive services are not reimbursable.**
- **Notes must be legible. Notes that are not legible are not reimbursable.**

GENERAL DOCUMENTATION RULES

- All Providers must refer and adhere to LACDMH Policy 401.02 and 401.03.
- All LACDMH Directly-Operated Providers must use the DMH approved forms or an approved electronic health record system for documentation. LACDMH Contract Providers must incorporate all LACDMH required documentation elements as referenced in this Manual and adhere to the forms guidelines identified in DMH Policy 401.02.
- All Directly-Operated Providers must refer and adhere to the LACDMH Clinical Records Guidelines.
- **Special client needs as well as associated interventions directed toward meeting those needs must be documented (LACDMH Policy 401.03):**
 - **Visual and hearing impairments**
 - **Client's whose primary language is not English** - Clients should not be expected to provide interpretive services through friends or family members. (See LACDMH Policy #200.03, "Language Interpreters", for further information.). Oral interpretation and sign language services must be available free of charge (State Contract)

NOTE: Just because assistance is documented, it does not necessarily mean it is claimable. Claimed notes for services must show how the service assists the client in accessing services or is a service intervention. The assistance must be claimed in accord with the focus of the client contact and the staff providing the service. Simply translating for the client is not considered an intervention.

NOTE: In order to obtain and/or transmit linguistically accurate information from clients who do not speak English as a first language, the Department has translated some of its forms into other languages. Whenever non-English forms are used, the English translation version must be printed on the back of the form. If that is not possible, the English version must be placed immediately adjacent to the non-English version in the clinical record. The English version should note that the document was signed on the non-English version.
 - **Cultural consideration – documentation must show that services took into account the client's culture.**

NOTE: Culture is "the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture defines how:

 - Health care information is received;
 - How rights and protections are exercised;
 - What is considered to be a health problem;
 - How symptoms and concerns about the problem are expressed;
 - Who should provide treatment for the problem; and
 - What type of treatment should be given." (*U.S. Department of Health and Human Services, Office of Minority Health (2013). The National Culturally and Linguistically Appropriate Services (CLAS) Standards.*)

Cultural considerations may include but are not limited to: racial/ethnic/national origin, religious/spiritual background or affiliation, gender/sexual orientation, other cultural considerations expressed by the consumer.

- **All entries in the client record shall include** (State Contract):
 - The date of service;
 - The signature of the person providing the service (or electronic equivalent), the person's type of professional degree, licensure, or job title; and the relevant identification number (if applicable);

NOTE: The signature (or electronic equivalent) of EACH person providing a service must be present .

 - The date the documentation was entered in the client record.

NOTE: When identifying professional license, abbreviations are acceptable so long as they are industry accepted abbreviations (e.g. LCSW, RN, MFT Intern, MD, etc). If staff does not have a professional license/title, then job title should be identified. Job title should be based on functional role such as case manager, mental health rehabilitation specialist, and care coordinator. Abbreviations for job title should not be used unless the Agency has an official list of job titles and their abbreviations. The relevant identification number includes license, certification or registration numbers.

- Co-signatures may **NEVER** be used to allow a staff person to perform a service that is not within his/her scope of practice. Co-signing a document means the co-signer has supervised the service delivery and assumes responsibility and liability for the service.
 - Services provided by students must have all documentation co-signed by a licensed individual acting within their scope of practice.
 - Services provided by unlicensed staff without a bachelor's degree in a mental health related field **or** two (2) years of mental health experience (paid or unpaid) delivering services must have all documentation co-signed by a licensed individual acting within their scope of practice until the experience/education requirement is met and the supervisor has determined that the staff person is competent to provide services and document independently.

NOTE: If the staff person requires co-signature, it must be on every document the staff signs.

MEDI-CAL MEDICAL NECESSITY

DESCRIPTION

Medical necessity is a term used by certain third party payers that encompasses criteria they feel are essential for reimbursement of services. If all the criteria making up medical necessity are not met, a payer will refuse or deny payment. While the wording of definitions vary slightly among payer sources, their intent is generally the same and compliance with one will often merit compliance with another.

The Medi-Cal Medical Necessity criteria has three components: diagnosis, impairment, and interventions. These are detailed below along with additional comments regarding EPSDT (Early Periodic Screening, Diagnosis, & Treatment) medical necessity criteria.

MEDICAL NECESSITY CRITERIA

All three of the following listed criteria must be met to be eligible for reimbursement (CCR §1830.205):

1. **An “included” Diagnosis from the most current ICD code set.** (See Appendix Item “Medi-Cal Included Diagnoses”)

NOTE: Having a diagnosis that is not “included” does not exclude a client from having his/her services reimbursed AS LONG AS services/interventions are directed toward the impairment resulting from an “included” diagnosis. Services/interventions for Medi-Cal must be directed towards addressing the “included” diagnosis except while conducting the assessment or emergency/crisis services. The diagnosis which services/interventions are directed towards should be listed as the Primary Diagnosis in the Clinical Record and in the LACDMH electronic system and must be an included diagnosis if services are to be claimed to Medi-Cal. The primary diagnosis of an episode will be the diagnosis associated with a claim.

In the LACDMH electronic system, all mental and behavioral health ICD diagnoses are listed, both those “included” and “excluded” for Medi-Cal reimbursement. .

2. **Impairment as a result of the “included” Diagnosis.** At least **one** of the following must apply:
 - a. a significant impairment in an important area of life functioning; e.g., living situation, daily activities, or social support
 - b. a probability of significant deterioration in an important area of life functioning
 - c. a probability a person under 21 years of age will not progress developmentally as individually appropriate (also see the following section on medical necessity for persons under 21 years of age)

NOTE: Impairments must clearly be identified in the Assessment along with a description of how those impairments are as a result of the included diagnosis. Simply stating or describing the impairment is not sufficient.

3. **Intervention: a person must meet each of the intervention criteria listed below.**
 - a. The focus of the proposed intervention is to address the condition in 2 above.
 - b. The expectation that the proposed intervention will:
 - 1) significantly diminish the impairment **OR**
 - 2) prevent significant deterioration in an important area of life functioning **OR**
 - 3) allow the child to progress developmentally as individually appropriate, unless conditions in the following section are met
 - c. The condition would not be responsive to physical health care based treatment.

Other Allowable Medical Necessity Criteria for Persons Under 21 Years of Age (CCR §1830.210)

If persons under 21 do not meet criteria (2)-Impairment and (3)-Intervention above, medical necessity is met when all of the following exist:

1. The person has an included diagnosis (see Appendix for listing)
2. The person has a condition that would not be responsive to physical health care based treatment

AND

3. Persons who do not meet the medical necessity criteria listed above will meet the medical necessity criteria per EPSDT (Title 22, CCR §51340) eligibility when specialty mental health services are needed to correct or ameliorate a defect, mental illness, or condition.

EPSDT Supplemental services should **not** be approved if it is determined that the service to be provided is accessible and available in an appropriate and timely manner as another service available from the provider.

Mental Health Services should not be approved in home and community based settings if it is determined that the total cost incurred for providing such services to the minor is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the minor's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner (CCR §1830.210).

DOCUMENTATION FOR MEDICAL NECESSITY THE CLINICAL LOOP

It is important to understand that while documentation rules include specific points at which medical necessity must be verified, these are not the only points at which medical necessity criteria must be met.

Every claimed service, other than those for assessment purposes and crisis intervention, must meet the test of medical necessity; i.e., the service must be directed towards reducing or ameliorating the effect of symptoms/behaviors of an included diagnosis causing functional impairments or, minimally, preventing an increase of those symptoms/behaviors or functional impairments. Each time a service is claimed, the staff person who delivered the service and submitted the claim is attesting that he/she believes the service met all medical necessity criteria as documented in the Clinical Record.

NOTE: This does not mean that every Progress Note must document all elements of medical necessity within the confines of the Progress Note. It simply means that there is sufficient documentation in the Clinical Record to support the intervention provided in the Progress Note.

THE CLINICAL LOOP

The “Clinical Loop” is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are Medi-Cal reimbursable. All services claimed to Medi-Cal, except for services for the purpose of assessment or crisis intervention MUST fit into the Clinical Loop and support Medical Necessity in order to be reimbursed.

The sequence of documentation on which Medical Necessity requirements converge is:

- The Assessment - The completion of an **Assessment** establishes the foundation for an included diagnosis and impairments in life functioning.
- The Client Treatment Plan - The demonstration of medical necessity is carried forward into the **Client Treatment Plan** where the diagnosis and impairments are used to establish treatment goals/objectives and the proposed interventions to effect the identified objectives.
- The Progress Note - **Progress Notes** document a service delivered that is related back to an intervention identified on the Client Treatment Plan. Progress Notes should also note the progress the client is making toward his/her objectives.

The Clinical Loop is not a one-time activity. The Clinical Loop occurs throughout the client’s treatment and should be reviewed and updated on a regular basis to ensure current interventions are consistent with current symptoms/behaviors and impairments documented in the Clinical Record.

Triage may be the first point of establishing Medical Necessity. While the presence of Medical Necessity cannot be determined from Triage alone, the presence of functional impairments can be determined by triage and/or the need to further assess for an included diagnosis setting the stage for further intake and assessment.

ASSESSMENT (LACDMH Policy 401.03)

DESCRIPTION

An Assessment is important in beginning to understand and appreciate who the client is and the interrelationship between the client’s symptoms/behaviors and the client as a whole person. The Assessment enables the reader to see the role of culture and ethnicity in the client’s life and documents the impact of collaterals, living situation, substance use, etc. on the mental health of the client. The Assessment identifies the client and his/her family’s strengths and identifies the stages of change/recovery for the

client. The formulation collected in an Assessment allows the client and staff to collaborate in the development of a mutually agreed upon plan of treatment and recovery. The assessment may be completed in one contact or over a period of time.

Assessments may only be completed by staff operating within their scope of practice and in accord with the Guide to Procedure Codes. Assessments must be completed for:

- New clients;
- Returning clients;
- Continuous clients.

In addition, assessments should be updated as clinically appropriate and whenever there is additional information gathered.

NEW CLIENT ASSESSMENT

Assessments for new clients (i.e. clients that require the creation of a Clinical Record) must be completed within 60 days of the initiation of services related to assessment or treatment. Any program accepting a client is responsible for ensuring there is a current, complete (all data elements below addressed) and accurate Assessment in the Clinical Record.

If using the LACDMH paper forms, the Full Assessment (or the Infancy, Childhood & Relationship Enrichment Initial Assessment - ICARE) should be used. In almost all cases, Directly-Operated Providers in the Integrated Behavioral Health Information System (IBHIS) should use the Full Assessment (or ICARE). In cases where the purpose of assessment is to provide information for immediate and non-ongoing services, Directly-Operated Providers in IBHIS may use a QA approved form and procedure with all required data elements below. Contractors with an EHRS should use the relevant form with all required data elements below .

New Client Assessment Requirements:

(State Contract unless otherwise noted):

- Assessor Information (LACDMH Requirement)
 - *Name*
 - *Discipline*
- Identifying Information and Special Service Needs (LACDMH Requirement)
 - *Name of Client*
 - *Date of Birth*
 - *Gender*
 - *Ethnicity*
 - *Preferred Language*
 - *Other relevant information*
- For Children, Biological Parents, Caregivers and Contact Information (LACDMH Requirement)
 - *Names*

- *Contact Information (phone or address)*
 - *Other relevant information*
- Presenting problem(s): The client's chief complaint, history of presenting problem(s), including current level of functioning, relevant family history and current family information;
 - *Precipitating Event/Reason for Referral*
 - *Current Symptoms/Behaviors including intensity, duration, onset and frequency*
 - *Impairments in Life Functioning*
- Client Strengths: Documentation of the beneficiary's strengths in achieving client plan goals;
 - *Client strengths to assist in achieving treatment goals*
- Mental Health History: Previous treatment, including providers, therapeutic modality (e.g. medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;
 - *Psychiatric Hospitalizations including dates, locations and reasons*
 - *Outpatient Treatment including dates, locations and reasons*
 - *Response to Treatment, Recommendations, Satisfaction with Treatment*
 - *Past Suicidal/Homicidal Thoughts or Attempts*
 - *Other relevant information*
- Risks: Situations that present a risk to the beneficiary and/or others, including past or current trauma;
 - *History of Trauma or Exposure to Trauma*
 - *Other relevant information*
- Medications: Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;
 - *Medication*
 - *Dosage/Frequency*
 - *Period Taken*
 - *Effectiveness, Response, Side Effect, Reactions*
 - *Other relevant information*
- Substance Exposure/Substance Use: Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;
 - *Risks*
 - *Use*
 - *Attitudes*
 - *Exposure*
 - *Other Relevant information*
- Medical History: Relevant physical health conditions reported by the client or a significant support person. Include name and address of current source of

medical treatment. For children and adolescents: include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;

- *Doctor's name and contact information*
- *Allergies*
- *Relevant medical information*
- *Developmental History (for children)*
- *Developmental milestones and environmental stressors (for children)*
- Relevant conditions and psychosocial factors affecting the client's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;
 - *Education/School history, status, aspirations*
 - *Employment History/Vocational information including means of financial support (for adults)*
 - *Legal/Juvenile court history and current status*
 - *Child abuse/protective service information (for children)*
 - *Dependent Care Issues (for adults)*
 - *Current and past relevant Living Situations including Social Supports*
 - *Family History/Relationships*
 - *Family strengths (for children)*
 - *Other relevant information*
- Mental Status Examination;
 - *Mental Status Examination*
- Clinical formulation based on presenting problems, history, mental status examination and/or other clinical data;
 - *Clinical formulation*
- A diagnostic descriptor consistent with the clinical formulation
 - *Diagnostic descriptor*
- A code from the most current ICD code set shall be documented consistent with the diagnostic descriptor;
 - *ICD diagnosis code*
 - *Specialty Mental Health Services Medical Necessity Criteria*
- Signature of a staff person allowed to perform a Psychiatric Diagnostic Assessment per the Guide to Procedure Codes
 - *Staff signature, discipline/title, identification number (if applicable) and date*

RETURNING CLIENT ASSESSMENT

Assessments for returning clients (i.e. clients returning for services after termination of services per LACDMH Policy 312.01 or 180 days of inactivity and NOT requiring a new Clinical Record) must be completed within 60 days of the initiation of services related to

assessment or treatment. Any program accepting a returning client is responsible for ensuring there is an assessment with the below data elements in the Clinical Record.

If using the LACDMH paper forms, the Re-Assessment should be used. In almost all cases, Directly-Operated Providers in the Integrated Behavioral Health Information System (IBHIS) should use the Assessment Addendum. In cases where the purpose of assessment is to provide information for immediate and non-ongoing services, Directly-Operated Providers in IBHIS may use a QA approved form and procedure with all required data elements below. Contractors with an EHRS should use the relevant form with all required data elements below.

Client Returning for Services Assessment Requirements:

- *Precipitating Event/Reason for Referral*
- *Current Symptoms/Behaviors including intensity, duration, onset and frequency*
- *Impairments in Life Functioning*
- *Client Strengths to assist in achieving treatment goals*
- *Updates/Changes to*
 - *Mental Health History including history of problem prior to precipitating event, psychiatric hospitalizations and outpatient treatment*
 - *Medications*
 - *Substance Use*
 - *Medical*
 - *Psychosocial History including education, employment, legal, current living arrangements and social supports, dependent care issues and family/relationships*
 - *Developmental History (for children)*
- *Mental Status Examination*
- *Clinical Formulation and Diagnostic Descriptor*
- *ICD Code consistent with clinical formulation and diagnostic descriptor*
- *Staff signature, discipline/title, identification number (if applicable) and date*

C O N T I N U O U S C L I E N T A S S E S S M E N T

Assessments for continuous clients (i.e. clients who have not had treatment terminated or 180 days of inactivity) must be completed every 3 years. The assessment should be completed three years from the date of the last assessment (either a new client assessment, returning client assessment or continuous client assessment). Any program treating a client for 3 continuous years is responsible for ensuring there is an assessment with the below data elements in the Clinical Record.

If using the LACDMH paper forms, the Re-Assessment should be used. Directly-Operated Providers in the Integrated Behavioral Health Information System (IBHIS)

should use the Assessment Addendum. Contractors with an EHRS should use the relevant form with all required data elements below .

Continuous Client Assessment Requirements:

- *Current Symptoms/Behaviors including intensity, duration, onset and frequency*
- *Impairments in Life Functioning*
- *Client Strengths to assist in achieving treatment goals*
- *Updates/Changes to*
 - *Mental Health History including psychiatric hospitalizations and outpatient treatment*
 - *Medications*
 - *Substance Use*
 - *Medical*
 - *Psychosocial History including education, employment, legal, current living arrangements and social supports, dependent care issues and family/relationships*
 - *Developmental History (for children)*
- *Mental Status Examination*
- *Clinical Formulation and Diagnostic Descriptor*
- *ICD Code consistent with clinical formulation and diagnostic descriptor*
- *Staff signature, discipline/title, identification number (if applicable) and date*

ASSESSMENT ADDENDUM

An addendum to the Assessment is required when there is additional information gathered, whether a change or an addition, after the completion of an Assessment and prior to providing any services that are not justified by the current Assessment.

If using the LACDMH paper forms, the Assessment Addendum should be used. For Directly-Operated Providers in the Integrated Behavioral Health Information System (IBHIS), the Assessment Addendum may be used. For Contractors with an EHRS, the relevant form should be used.

CLIENT TREATMENT PLAN

(LACDMH Policy 401.03)

DESCRIPTION

Consistent with the philosophy and requirements of State and Federal funding sources, the Client Treatment Plan focuses on individualized, strengths-based services; addresses linguistic and interpretive needs; supports family involvement and encourages client participation and agreement with the plan. It is best practice for treatment planning to occur with the client present and there must be evidence of the client's participation in the treatment planning process. The client's signature on the Client Treatment Plan provides this evidence. The Client Treatment Plan is not final unless signed by the appropriate staff and client/responsible adult. See "Additional Information" below for signature requirements.

The Client Treatment Plan must clearly address the symptoms, behaviors and/or impairments identified in the most current Assessment and utilize the client's strengths to achieve his/her goals.

It is best practice for Client Treatment Plan objectives, and the proposed interventions supporting those objectives, to be written to the Client Treatment Plan by an AMHD for whom the services are within scope of practice. When the services are outside the scope of practice of the writer, irrespective of whether the writer is an AMHD, a face-to-face discussion between the writer and an individual for whom the interventions are within scope of practice must take place prior to the objectives/interventions being written. This discussion must be of sufficient detail as to provide the writer with clear direction on all materially important treatment related elements of the objectives/interventions. In these instances, the responsibility for the content of the objectives/interventions that result from the aforementioned process remains with the individual for whom the interventions are within scope of practice.

When provided, the following treatment services must be associated with an objective(s) on the Client Treatment Plan:

- Mental Health Services
- Medication Support Services
- Targeted Case Management Services
- Therapeutic Behavioral Services (TBS)
- Day Treatment Intensive Services
- Day Rehabilitation Services
- Crisis Residential Services
- Transitional and Long Term Residential Services

Client Treatment Plans must be completed for all above treatment services and fall into two categories:

- Annual;
- Update.

The Annual Client Treatment Plan covers all services to be provided to a client. The Update Client Treatment Plan is an addendum to the Annual. It covers those objectives or services to be reviewed, added, modified, or deleted prior to the review deadline of the Annual Client Treatment Plan.

NOTE: Treatment services are services addressing client mental health concerns that are not primarily for the purpose of assessment, plan development, crisis intervention or, during the first 60 days for new/returning clients, linkage to other mental health programs per DMH Policy and Procedure 401.03.

ANNUAL CLIENT TREATMENT PLAN

The Annual Client Treatment Plan is required after the completion of a new client assessment or returning client assessment and prior to the initiation of treatment services for a client. For Crisis Residential Services the Client Treatment Plan must be completed within 72 hours of admission to the program.

The Annual Client Treatment Plan shall also be reviewed and modified, if appropriate, minimally every 365 days from the start date of the last Annual Client Treatment Plan. If the client is not available to participate in the review prior to the expiration of the 365 day period, the Annual Client Treatment Plan shall be reviewed and updated with the client at the next contact with the client and prior to additional treatment services being provided. The review shall be documented in the progress note, including the outcome(s) of the previous treatment plan.

Annual Client Treatment Plan Required Elements:

(State Contract except as otherwise noted)

- Statement of long-term goals (treatment outcome) in the client's words (LACDMH Requirement);
- Goals/treatment objectives related to the client's mental health needs and functional impairments objectives that are specific, measurable/quantifiable, achievable, realistic, time-bound (SMART);
- Proposed types(s) of services including modality (when appropriate);
- Detailed description of the proposed interventions designed to address the identified functional impairments;
- Proposed frequency and duration (if less than one year) of interventions;
- Client and family involvement (LACDMH Requirement)
- Evidence the client was offered a copy of the plan
- Linguistic and interpretive needs (LACDMH Requirement)
- Required staff signature, discipline/title, identification number (if applicable) and date (see below for additional information)
- Client/Responsible Adult Signature and Date (see below for additional information)

UPDATE CLIENT TREATMENT PLAN

An Update Client Treatment Plan shall be done for the objectives associated with the following types of services and mandated review periods:

- Crisis Residential programs - Weekly;
- Transitional Residential programs – Every 6 Months;
- Long Term Residential programs –Every 6 Months;
- Therapeutic Behavioral Services – Every 3 Months;
- Day Treatment Intensive programs – Every 3 Months;
- Day Rehabilitation – Every 6 Months.

Each objectives associated with an above type of service on the Client Treatment Plan shall be reviewed, renewed, updated/modified or deleted (as appropriate) prior to the due date or prior to services being provided after the review date.

The Update Client Treatment Plan shall also be completed as clinically appropriate (i.e. when a change in treatment is warranted). This would include adding an objective(s) and/or intervention(s) or editing an objective(s) and/or intervention(s) on the current Client Treatment Plan.

Update Client Treatment Plan Required Elements:

When renewing, adding or modifying an objective to the Client Treatment Plan, the required elements include:

- Goals/treatment objectives related to the client's mental health needs and functional impairments objectives that are specific, measurable/quantifiable, achievable, realistic, time-bound (SMART);
- Proposed types(s) of services including modality (when appropriate);
- Detailed description of the proposed interventions designed to address the identified functional impairments;
- Proposed frequency and duration (if less than one year) of interventions;
- Client and family involvement (LACDMH)
- Evidence the client was offered a copy of the plan
- Linguistic and interpretive needs (LACDMH)
- Required staff signature, discipline/title, identification number (if applicable) and date
- Client/Responsible Adult Signature and Date

When renewing, adding or modifying an intervention modality to the Client Treatment Plan, the required elements include:

- Proposed types(s) of services including modality (when appropriate);
- Detailed description of the proposed interventions designed to address the identified functional impairments;
- Proposed frequency and duration (if less than one year) of interventions;

- Client and family involvement (LACDMH)
- Linguistic and interpretive needs (LACDMH)
- Required staff signature, discipline/title, identification number (if applicable) and date

ADDITIONAL INFORMATION

Required Staff Signatures:

- For all objectives, an Authorized Mental Health Discipline (AMHD);

NOTE: Signature by an AMHD minimally means services are under the direction of, or in consultation with, the AMHD (see General Documentation Rules).

- For all objectives, the staff person who has written the objective (LACDMH Requirement);
- For all Medication Support Service interventions, a staff person within scope of practice (i.e. if prescribing medications is an indicated intervention, an MD/DO or NP must sign) (LACDMH);
- For services claimed to Medicare/Private Insurance: an MD/DO (Medicare and Private Insurance Carriers as noted in LACDMH Policy 401.04).

Required Client/Responsible Adult Signatures:

- For all objectives, the Client or a Parent, Authorized Caregiver, Guardian, Conservator, Personal Representative for Treatment.

NOTE: The signature of the person who has signed the Consent for Services is preferred; if the person signing the Consent for Services is unavailable, a caregiver of the client or a client of any age may sign as appropriate.

When the client does not sign the Client Treatment Plan, a written explanation as to the reason for the lack of signature must be documented on the Client Treatment Plan. In cases where the client is unable to sign the plan due to their mental state (e.g. agitated or psychotic), subsequent attempts to obtain the signature must be made and documented when the clinical record indicates that the situation that justified the initial absence of signature is no longer a factor or in effect.

When the client, or other required participant in the treatment planning process, is unwilling to sign the Client Treatment Plan due to a disagreement with the plan, every reasonable effort should be made to adjust the Client Treatment Plan in order to achieve mutually agreed-upon acceptance by the client or other required participant, and the clinician.

PROGRESS NOTES (LACDMH Policy 401.03)

DESCRIPTION

Progress Notes provide a means of communication and continuity of care between all service delivery staff, as well as, provide evidence of the course of the client's illness and/or condition. Progress Notes must be used to describe how services provided reduced impairment, restored functioning or prevented significant deterioration in an important area of life functioning as described in the Client Treatment Plan.

In order to be reimbursed, a Progress Note must be present to provide evidence of each claimed service based on the frequency required for that service as described in the corresponding chapter of this manual.

PROGRESS NOTES

Progress Note Requirements:

(State Contract except as otherwise noted)

- Date of service;
- Procedure code (LACDMH Requirement);
- Duration of service (Face-to-Face Time and all Other Time for Mode 15);
- For group, the number of total clients present;
- Relevant aspects of client care, including documentation supporting medical necessity;
- Relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
- Interventions applied;
- Client's response to the interventions;
- Client's progress towards objectives when completing the Client Treatment Plan (LACDMH Requirement);
- Location of the interventions;
- Referrals to community resources and other agencies, when appropriate;
- Follow-up care and, if appropriate, a discharge summary;
- Staff signature, discipline/title, identification number (if applicable) and date

NOTE: Any Mental Health Services (MHS) or Medication Support Services provided to a client in Day Treatment Intensive or Day Rehabilitation must have the start and end time of the face to face contact documented to ensure that the time spent providing these services is not counted toward the total hours/minutes the client actually attended the program (LACDMH).

NOTE: It is best practice to complete the discharge summary as part of a collaborative process with the client and/or collateral during an in person contact or, minimally, a phone contact. A discharge summary includes the following elements:

- A brief treatment summary;
- A status update on the client's progress toward their treatment plan objectives;
- Referrals provided (if applicable);
- Reason for termination of services;
- Follow-up plans (if applicable);
- Other pertinent information such as whether medications were provided upon termination.

Signature Requirements

See General Documentation Rules for additional information regarding signature and co-signature requirements.

The signature (or electronic equivalent) of the person providing the service including the person's type of professional degree, licensure or job title; and the relevant identification number (if applicable) must be on every progress note.

When more than one staff participates in the same service, the names of any staff participating in the service must be included in the note with his/her specific intervention/contribution, time and signature (or electronic equivalent).

NOTE: The signature (or electronic equivalent) of EACH person providing the service for which time will be claimed must be present on the progress note.

Frequency of Progress Notes

Progress notes shall be documented at the frequency by type of service indicated below:

- Every service contact
 - ✓ Mental Health Services
 - ✓ Medication Support Services
 - ✓ Crisis Intervention
 - ✓ Targeted Case Management
- Daily
 - ✓ Crisis Residential
 - ✓ Crisis Stabilization(1x/23hr period)
 - ✓ Day Treatment Intensive
- Weekly
 - ✓ Day Treatment Intensive: Clinical Summary
 - ✓ Day Rehabilitation
 - ✓ Adult Residential

SERVICE COMPONENTS (State Plan Amendments)

DEFINITION

Service components are defined in the State Plan Amendment and State Contract and identify the reimbursable elements of Specialty Mental Health Services of the California Medicaid program. To be reimbursed under the Medicaid program, the need for the treatment service must be established by an assessment and documented in the client care plan. Service components are not procedure codes. Procedure codes are part of the HIPAA Transaction and Codes Set for compliant claiming and utilize two nationally recognized coding systems: Current Procedural Terminology (CPT) codes and the Level II Health Care Procedure Code System (HCPCS). Federally defined CPT or HCPCS codes are used for HIPAA compliant claims to identify a specific service. While service components are always reimbursable, procedure codes may or may not be reimbursable.

SERVICE COMPONENTS

All definitions are from the DHCS State Plan Amendment (SPA) unless otherwise noted. Service components lacking specific SPA definitions must conform to the general requirement of addressing identified mental health needs as established by an assessment and documented in the client treatment plan (aka the clinical loop). The following service components apply to Mode 10 and Mode 15 services as identified in Chapters 2 and 4.

Adjunctive Therapies: Therapies in which both staff and clients participate, such therapies may utilize self-expression, such as art, recreation, dance, or music, as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed toward achieving client plan goals. Adjunctive therapies assist the client in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive therapies provided as a component of Day Rehabilitation or Day Treatment Intensive are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the client's needs identified in the client care plan.

Assessment (Mental Health Services): A service activity designed to evaluate the current status of a client's mental, emotional, or behavioral health. Assessment includes one or more of the following: mental status determination, analysis of the client's clinical history, analysis of relevant biopsychosocial and cultural issues and history, diagnosis, and the use of testing procedures.

Assessment (Targeted Case Management): A service activity to determine the need for establishment or continuation of targeted case management services to access any medical, educational, social or other services. Assessment activities may include: taking client history, identifying the client's needs and completing related documentation, reviewing all available medical, psychosocial, and other records, and gathering information from other sources such as family members, medical providers, social workers, and educators to form a complete assessment of the client and assessing support network availability, adequacy of living arrangements, financial status, employment status, and potential training needs.

Assessment (Therapeutic Behavioral Service): An activity conducted by a provider to assess a child/youth's current problem presentation, maladaptive at risk behaviors that require TBS, member class inclusion criteria, and clinical need for TBS services. Periodic re-assessments for continued medical necessity and clinical need for TBS should also be recorded as TBS.

Collateral: A service activity to a significant support person or persons in a client's life for the purpose of providing support to the client in achieving client treatment plan goals. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the client in increasing resiliency, recovery, or improving utilization of services; consultation and training of the mental illness and its impact on the client; and family counseling with the significant support person(s) to improve the functioning of the client. The client may or may not be present for the service activity.

NOTE: For the purpose of claiming, outside agency staff, school teachers, and board and care operators are **not** considered to be within this definition. Collateral sessions (with one or more clients represented) must be directed exclusively to the mental health needs of the client [CCR §1840.314(b)]. Examples are: interpretation or explanation of results of psychiatric, other medical examinations or procedures, or other accumulated data to family or significant other(s), or advising them how to assist the client.

Community Meetings: Meetings that occur at a minimum once a day, but may occur more frequently as necessary, to address issues pertinent to the continuity and effectiveness of the therapeutic milieu. Community meetings actively involve staff and clients. For Day Treatment Intensive, meetings include a staff person whose scope of practice includes psychotherapy. For Day Rehabilitation, meetings include a staff person who is a physician, a licensed/waivered/registered psychologist, clinical social worker, professional clinical counselor, or a marriage and family therapist, a registered nurse, a psychiatric technician, a licensed vocational nurse, or a mental health rehabilitation specialist. Meetings address relevant items including the schedule for the day, current events, individual issues clients or staff wish to discuss to elicit support of

the group, conflict resolution within the milieu, planning for the day, the week or for special events, follow-up business from previous meetings or from previous day treatment experiences, and debriefing or wrap-up. Community meetings in the context of the therapeutic milieu are intended to assist the client towards restoration of their greatest possible level of functioning consistent with the client's needs identified in the client care plan by providing a structured and safe environment in which to practice strategies and skills which enhance the client's community functioning, including but not limited to, isolation reducing strategies, communication skills particularly in terms of expressing the client's needs and opinions, problem solving skills, and conflict resolution skills.

Crisis Intervention: An unplanned, expedited service, to or on behalf of a client to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a client to cope with a crisis, while assisting the client in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.

NOTE: Crisis Intervention is both a service component and type of service under Mode 15.

Evaluation of Clinical Effectiveness and Side Effects

Evaluation of the Need for Medication

Medication Education: Includes the instruction of the use, risks, and benefits of and alternatives for medication

Medication Support Services: Includes one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication Support Services are individually tailored to address the client's need and are provided by a consistent provider who has an established relationship with the client.

NOTE: Medication Support Services is both a service component and type of service under Mode 15.

Monitoring and Follow Up: Activities and contacts necessary to ensure the Client Treatment Plan is implemented and adequately addresses the client's needs. This activity includes at least annual monitoring to determine:

- Services are provided in accordance with the Client Treatment Plan;
- Services in the Client Treatment Plan are adequate;
- If there are changes in the needs or status of the client, there are necessary adjustments in the Client Treatment Plan and service arrangements with providers.

Obtain Informed Consent

Plan Development: A service activity that consists of one or more of the following: development of client treatment plans, approval of client treatment plans and/or monitoring of a client's progress.

NOTE: If the plan development is related to a service activity which falls under the general service description of Mental Health Services, then Mental Health Services should be claimed. If the plan development is related to a service activity which falls under the general service description of Medication Support Services, then Medication Support Services should be claimed. If the plan development is related to a service activity which falls under Targeted Case Management, then Targeted Case Management should be claimed. If the plan development is related to a service activity which falls under Crisis Intervention, then Crisis Intervention should be claimed. In each of these cases, the service must be within the scope of practice of the practitioner claiming for the service.

Process Groups: Groups facilitated by staff to help clients develop skills necessary to deal with their individual problems and issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems.

Psychotherapy: The use of psychological methods within a professional relationship to assist the client or clients to achieve a better psychosocial adaptation, to acquire a greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individual, groups, or communities in respect to behavior, emotions and thinking in respect to their intrapersonal and interpersonal processes. Psychotherapy shall be provided by licensed, registered, or waived staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention. (State Contract)

Referral: Linkage to other needed services and supports.

Referral and Related Activities: To help a client obtain needed services including activities that help link a client with medical, alcohol and drug treatment, social, educational providers or other programs and services that are capable of providing needed services; to intervene at the onset of a crisis to coordinate/arrange for provision of other needed services; to identify, assess and mobilize resources to meet the client's needs including consultation and intervention on behalf of the client with Social Security, schools, social services and health departments, and other community agencies; placement coordination services when necessary to address the identified mental health condition, including assessing the adequacy and appropriateness of the client's living arrangement.

Rehabilitation: A recovery or resiliency focused service activity identified to address a mental health need in the client treatment plan. This service activity provides assistance in restoring, improving, and/or preserving a client's functional, social, communication, or daily living skills to enhance self-sufficiency or self regulation in multiple life domains relevant to the developmental age and needs of the client.

Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a client or a group of clients.

Skill Building Groups: In these groups, staff shall help clients identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, clients identify skills that address symptoms and increase adaptive behaviors. (State Contract)

Therapy: A service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a client in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a client or a group of clients and may include family therapy directed at improving the client's functioning and at which the client is present.

Therapeutic Behavioral Service (TBS) Intervention: An individualized one-to-one behavioral assistance intervention to accomplish outcomes specifically outlined in the written TBS client plan. A TBS intervention can be provided either through face-to-face intervention or by telephone; however, a significant component of this service activity is having the staff person on-site and immediately available to intervene for a specified period of time.

Therapeutic Milieu: A therapeutic program structured by process groups and skill building groups that has activities performed by identified staff; takes place for the continuous hours of program operation; includes staff and activities that teach, model and reinforce constructive interactions; and includes peer and staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing adjunctive distress. It includes behavior management interventions that focus on teaching self-management skills that children, youth, adults, and older adults may use to control their own lives, deal effectively with present and future problems, and function well with minimal or no additional therapeutic intervention.

CHAPTER 2

Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15)

SERVICE OVERVIEW & REIMBURSEMENT RULES

General Rules

Documentation Rules

TYPES OF SERVICES

Mental Health Services (MHS)

Medication Support Services (Meds or MSS)

Crisis Intervention (CI)

Targeted Case Management (TCM)

Therapeutic Behavioral Services

SERVICE OVERVIEW & REIMBURSEMENT RULES

GENERAL RULES

The reimbursable unit for these services is staff time reported in the DMH electronic data system and claimed in minutes. Medicare reimburses for individual services based on face-to-face time, hence to appropriately claim to both Medicare and Medi-Cal, the total service time for any Rendering Provider must be broken out into face-to-face and other time to ensure the correct Procedure Code selection. When required, both of these times will need to be entered into the DMH electronic system and documented in the clinical record. The total time is used for claiming to Medi-Cal.

NOTE: All Mental Health Services must have authorization from the Department's Central Authorization Unit prior to delivery when delivered in conjunction with Day Treatment Intensive or Day Rehabilitation.

DOCUMENTATION RULES

(See also Chapter 1, "General Documentation Rules" and subsequent sections for specific rules related to specific services.)

Frequency of Documentation:

For all Mode 15 services including Mental Health Services, Medication Support Services, Crisis Intervention and Targeted Case Management, every service contact must be documented on a separate progress note.

NOTE: For the purpose of Targeted Case Management, a single service contact may include multiple service activities (e.g. telephone calls) performed within the same calendar day and intended to accomplish the same specific objective.

Claiming:

- The exact number of minutes used by persons providing a reimbursable service shall be reported and billed (CCR §1840.316).
- The total time claimed shall not exceed the actual time utilized for claimable services (CCR §1840.316).
- In no case shall the units of time reported or claimed for any one person exceed the hours worked (CCR §1840.316).

- A service is an individual service when services are directed towards or on behalf of only one client.
- A service is a group service when services are directed towards or on behalf of more than one client at the same time.
- For group services, the staff members' time must be prorated to each client based on the total number of persons receiving the service. This number must include both DMH and non-DMH clients to ensure that Medi-Cal is not claimed time for services to non-beneficiaries.
- When more than one staff member provides a service to more than one client at the same time, the total time spent by all staff shall be added together to yield the total claimable services.

Site and Contact Requirements:

The following applies to Mental Health Services (CCR §1840.324); Medication Support Services (CCR §1840.326); Crisis Intervention (CCR §1840.336); and Targeted Case Management (CCR §1840.342):

Services may be provided face-to-face, by telephone or by telepsychiatry with the client or significant support persons. Services may be provided anywhere in the community.

Documentation Rules:

- Progress Notes must explicitly document how services without face-to-face or telephone contact with the client (e.g. report writing, consultation, record review and plan development) benefit the client and meet the requirements of Medical Necessity.
- When services are being provided to or on behalf of a client by two or more staff in a single contact each person's involvement shall be documented in the context of the mental health needs of the client. (CCR §1840.314) This may be documented in a single note.
- When two or more significant and distinct services or service types are delivered within a single contact, each service must be documented in a separate progress note that meets all documentation requirements. It is not appropriate to combine multiple significant and distinct services under a single progress note that simply reflects the predominant service.

NOTE: Plan Development services are an exception and may be combined into a single progress note with another service.

- When two or more staff provide significant and distinct services in a single contact, each staff should write a separate note and claim separately to an appropriate procedure code for the service provided by that individual staff member.

TYPES OF SERVICES

MENTAL HEALTH SERVICES

Definition (State Plan Amendment)

Mental Health Services are individual, group or family-based interventions that are designed to provide reduction of the client’s mental or emotional disability, restoration, improvement and/or preservation of individual and community functioning, and continued ability to remain in the community consistent with the goals of recovery, resiliency, learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive.

Service Components (State Plan Amendment)

Mental Health Services include one or more of the following service components:

- Assessment
- Plan Development
- Therapy
- Rehabilitation
- Collateral

Claiming (Mode, Service Function and Procedure Code Reference):

Mental Health Services are claimed under Mode 15. Mental Health Services include the following Service Function Codes:

- 42 – Individual
- 52 – Group
- 34 – Psychological Testing
- 10 – Collateral
- 44 – Fee For Service MHS
- 57 – Intensive Home Based Services (See DHCS Katie A Manual)

Refer to the Guide to Procedure Codes for a complete listing of procedure codes and disciplines which may be claimed as Mental Health Services. Mental Health Services shall be claimed in accord with Scope of Practice and the Guide to Procedure Codes.

Medi-Cal Lockouts (applies to all Mental Health Services):

- ⇒ Mental Health Services are not reimbursable on days when Crisis Residential Treatment Services (CCR §1840.364), Psychiatric SD/MC Inpatient Hospital Services (CCR §1840.215), or Psychiatric Health Facility Services (CCR §1840.370) are reimbursed, except on the day of admission to any of these facilities.
- ⇒ Mental Health Services are not reimbursable when provided by Day Rehabilitation or Day Treatment Intensive staff during the same time period that Day Rehabilitation or Day Treatment Intensive Services are being provided (CCR §1840.360).
- ⇒ Mental Health Services are not reimbursable when provided during the same time that Crisis Stabilization-Emergency Room or Urgent Care is provided. Exception is Targeted Case Management (CCR §1840.368).
- ⇒ Providers may not allocate the same staff's time under the two cost centers of Adult Residential and Mental Health Services for the same period of time (CCR §1840.362).
- ⇒ Intensive Home Based Services (IHBS) may not be provided to children/youth in Group Homes. IHBS can be provided outside the Group Home setting to children/youth that are transitioning to a permanent home environment to facilitate the transition during single day and multiple day visits (DHCS Katie A Manual page 13).

Additional Information:

In addition to the Documentation Requirements noted in Chapter 1 and the beginning of Chapter 2, the following documentation and claiming rules apply:

- For psychological testing, separate claims may be submitted, with appropriate accompanying documentation, for both the administration of tests and the preparation of the report in accord with the date the services were actually delivered.
- Psychological Testing is a psychodiagnostic assessment of personality, development and cognitive functioning. For children, referrals are made to clarify symptomatology, rule out diagnoses and help delineate emotional from learning disabilities.

M E D I C A T I O N S U P P O R T S E R V I C E S

Definition (State Plan Amendment):

Medication support services include one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication Support Services are individually tailored to address the client's need and are provided by a consistent provider who has an established relationship with the client.

Service Components (State Plan Amendment)

Medication Support Service components include:

- Evaluation of the need for medication
- Evaluation of clinical effectiveness and side effects of medication
- The obtaining of informed consent
- Medication education including instruction in the use, risks and benefits of and alternatives for medication
- Collateral
- Plan Development

Claiming (Mode, Service Function and Procedure Code Reference):

Medication Support Services are claimed under Mode 15. Medication Support Services include the following Service Function Codes:

- 62 – Medication Support

Refer to the Guide to Procedure Codes for a complete listing of procedure codes which may be claimed as Medication Support Services. Medication Support Services shall be claimed in accord with Scope of Practice and the Guide to Procedure Codes.

Medi-Cal Lockouts:

- ⇒ Medication Support Services are not reimbursable on days when Psychiatric Inpatient Services (CCR §1840.215) or Psychiatric Health Facility Services (CCR §1840.370) are reimbursed, except for the day of admission to either service.
- ⇒ A maximum of four hours of Medication Support Services per client per calendar day is Medi-Cal reimbursable (CCR §1840.372).

Additional Information:

In addition to the Documentation Requirements noted in Chapter 1 and the beginning of Chapter 2, the following documentation and claiming rules apply:

- Medication Support Services that are provided as an adjunct to a Residential or Day Treatment Intensive/Day Rehabilitation program shall be billed separately from that service.
- When Medication Support Services are provided to a client by a physician and nurse concurrently, the time of both staff should be claimed. If both staff provide the same service (e.g. medication education), then one note may be written that covers both staff and one claim submitted that includes the time of both staff. If two staff provide different services during the contact (e.g. the physician writes a prescription and the nurse gives an injection), two notes should be written with each staff submitting his/her own claim with his/her own time.
- If a staff person ineligible to claim Medication Support Services participates in the medication related contact, then the ineligible staff person must write a separate note documenting service time as either Targeted Case Management or Mental Health Services, in accord with the service the staff provided.
- If medications are prescribed, there must be a medication specific Informed Consent (Outpatient Medication Review or court order) completed per LAC-DMH Policy 306.02 Standards for Prescribing and Furnishing Psychoactive Medications (State Contract; CCR §851) that includes the following data elements:
 - The reason for taking such medications
 - Reasonable alternative treatments available, if any
 - Type of medication
 - Range of frequency (of administration)
 - Dosage
 - Method of administration
 - Duration of taking the medication
 - Probable side effects
 - Possible side effects if taken longer than 3 months
 - Consent once given may be withdrawn at any time
 - Date of medication consent
 - Signature of the person providing the service, type of professional degree and licensure/job title

CRISIS INTERVENTION

Definition (State Plan Amendment):

Crisis Intervention is an unplanned, expedited service, to or on behalf of a client to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a client to cope with a crisis, while assisting the client in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.

Service Components (State Plan Amendment)

Crisis Intervention service components include:

- Assessment
- Collateral
- Therapy
- Referral

Claiming (Mode, Service Function and Procedure Code Reference):

Crisis Intervention is claimed under Mode 15. Crisis Intervention includes the following Service Function Codes:

- 77 – Crisis Intervention

Refer to the Guide to Procedure Codes for a complete listing of procedure codes which may be claimed as Crisis Intervention. Crisis Intervention shall be claimed in accord with Scope of Practice and the Guide to Procedure Codes.

Medi-Cal Lockouts (CCR §1840.366):

⇒ Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facilities Services, Psychiatric Nursing Facility Services, or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services.

⇒ The maximum amount billable for Crisis Intervention in a 24 hour period is 8 hours.

Additional Information:

In addition to the Documentation Requirements noted in Chapter 1 and the beginning of Chapter 2, the following documentation and claiming rules apply:

- The acuity of the client or situation which jeopardizes the client's ability to maintain community functioning must be clearly documented.

- If an out-of-office situation is presented to a responding staff member as a crisis and the staff member finds the situation not to be a crisis upon arrival, the service may still be claimed as Crisis Intervention if the crisis described in the originating call is so documented (See Appendix for Quality Improvement Communiqué No. 4, December 13, 1993).

TARGETED CASE MANAGEMENT

Definition (State Plan Amendment):

Targeted Case Management means services that assist a client to access needed medical, alcohol and drug treatment, educational, social, prevocational, vocational, rehabilitative, or other community services.

Targeted Case Management includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for establishment or continuation of targeted case management services to access any medical, educational, social or other services.
2. Development and periodic revision of a plan to access the medical, social, educational, and other services needed by the client.
3. Referral and related activities.
4. Monitoring and follow-up activities.

Service Components (State Plan Amendment):

Targeted Case Management service components include:

- Assessment
- Plan Development
- Referral and Related Activities
- Monitoring and Follow-Up

Claiming (Mode, Service Function and Procedure Code Reference):

Targeted Case Management is claimed under Mode 15. Targeted Case Management includes the following Service Function Codes:

- 04 – Targeted Case Management
- 07 – Intensive Care Coordination (See DHCS Katie A Manual)

Refer to the Guide to Procedure Codes for a complete listing of procedure codes which may be claimed as Targeted Case Management. Targeted Case Management shall be claimed in accord with Scope of Practice and the Guide to Procedure Codes.

Medi-Cal Lockouts (CCR §1840.374):

- ⇒ Targeted Case Management Services are not reimbursable on days when the following services are reimbursed, except for day of admission or for placement services as provided below:
- Psychiatric Inpatient Hospital Services
 - Psychiatric Health Facility Services
 - Psychiatric Nursing Facility Services

Targeted Case Management Services, solely for the purpose of coordinating placement of the client on discharge from the hospital, psychiatric health facility or psychiatric nursing facility, may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility.

NOTE: Targeted Case Management is **reimbursable** during the same time Crisis Stabilization is provided. (No other specialty mental health service is reimbursable during the same period Crisis Stabilization is reimbursed.) (CCR §1840.368)

- ⇒ Targeted Case Management Services are not reimbursable when provided to a client who is receiving services in an Institution for Mental Diseases (IMD) except for clients aged 21 and younger receiving services as described in 42 CFR 440.160 and clients aged 65 and older receiving services described in 42 CFR 440.140 (State Plan Amendment)

Additional Information:

In addition to the Documentation Requirements noted in Chapter 1 and the beginning of Chapter 2, the following documentation and claiming rules apply:

THERAPEUTIC BEHAVIORAL SERVICES

Note: Therapeutic Behavioral Services are an EPSDT Supplemental Specialty Mental Health Service (CCR §1810.215). TBS is never a primary therapeutic intervention; it is always used in conjunction with a primary specialty mental health service.

Definition (DHCS Information Notice No.:08-38)

TBS are a one-to-one behavioral mental health service available to children/youth with serious emotional challenges who are under 21 years old and who are eligible for a full array of Medi-Cal benefits without restrictions or limitations (full scope Medi-Cal). TBS can help children/youth and parents/caregivers, foster parents, group home staff, and school staff learn new ways of reducing and managing challenging behaviors as well as strategies and skills to increase the kinds of behavior that will allow children/youth to be

successful in their current environment. TBS are designed to help children/youth and parents/caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the needs of the child/youth and family. TBS are never a stand-alone therapeutic intervention. It is used in conjunction with another mental health service.

TBS can be provided anywhere in the community: at home, school, other places such as after-school programs and organized recreation program, except during Medi-Cal lockouts.

TBS is not allowable when:

1. Services are solely:
 - For the convenience of the family or other caregivers, physician, or teacher;
 - To provide supervision or to assure compliance with terms and conditions of probation;
 - To ensure the child/youth's physical safety or the safety of others, e.g., suicide watch; or
 - To address behaviors that are not a result of the child/youth's mental health condition.
2. The children/youth can sustain non-impulsive self directed behavior, handle themselves appropriately in social situations with peers, and appropriately handle transitions during the day
3. The child/youth will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision.
4. The children/youth is currently admitted on an inpatient psychiatric hospital, psychiatric health facility, nursing facility, IMD, or crisis residential program.
5. On-Call Time for the staff person providing TBS (note, this is different from "non-treatment" time with staff who are physically "present and available" to provide intervention – only the time spent actually providing the intervention is a billable expense).
6. The TBS staff provides services to a different child/youth during the time period authorized for TBS.
7. Transporting a child or youth. (Accompanying a child or youth who is being transported may be reimbursable, depending on the specific, documented, circumstances).
8. TBS supplants the child or youth's other mental health services provided by other mental health staff.

Service Components (TBS Manual)

TBS include one or more of the following service components:

- Assessment (TBS)
- Plan Development
- TBS Intervention
- Collateral

Claiming (Mode, Service Function and Procedure Code Reference):

TBS is claimed under Mode 15. TBS includes the following Service Function Codes:

- 58 – Therapeutic Behavioral Service

Refer to the Guide to Procedure Codes for a complete listing of procedure codes and disciplines which may be claimed as TBS. TBS shall be claimed in accord with Scope of Practice and the Guide to Procedure Codes.

Medi-Cal Lockouts (TBS Manual):

- ⇒ TBS is not reimbursable on days when Crisis Residential Treatment Services, Inpatient Psychiatric Services or Psychiatric Health Facility Services are reimbursed by Medi-Cal, except for the day of admission to the facility .
- ⇒ TBS is not reimbursable during the same time period that Crisis Stabilization is reimbursed by Medi-Cal.

Additional Information (TBS Manual):

1. Staff Qualifications

Staff providing TBS services should be trained in functional behavioral analysis with an emphasis on positive behavioral interventions.

2. Class Criteria and Supplemental Assessment

In addition to the medical necessity and assessment requirements set forth in Chapter 1, any TBS recipient requires a Supplemental TBS Assessment be completed prior to the initiation of TBS that verifies the TBS recipient meets TBS “class criteria” requirements and is eligible to receive TBS services except as allowed in number three (3) below. Class criteria requirements include:

- The child/youth is under the age of 21 and has Full Scope Medi-Cal
- The child/youth is placed in a group home facility of RCL 12 or above or in a locked treatment facility for the treatment of mental health needs; OR

- The child/youth is being considered for placement in an RCL 12 or above (whether or not an RCL 12 or above placement is available) or a locked treatment facility for the treatment of mental health needs (whether or not the psychiatric facility is available); OR
- The child/youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting mental health diagnosis within the preceding 24 months; OR
- The child/youth has previously received TBS while a member of the certified class; OR
- The child/youth is at risk of psychiatric hospitalization.

The staff person completing the Supplemental TBS Assessment must be someone whose scope includes Psychiatric Diagnostic Evaluations. If using the LACDMH paper forms, the Supplemental TBS Assessment should be used. For Contractors with an EHRS, the relevant form with all the following required data elements should be used.

- **Verification of Medical Necessity:** Identify that the child/youth meets the medical necessity criteria specifically for the provision of TBS.
- **Verification of full-scope Medi-Cal**
- **Member Eligibility:** Determine that the client/youth meets class criteria.
- **Targeted Behavior(s):** Identify the specific behaviors that jeopardize continuation of the current residential placement or put the child/youth at risk for psychiatric hospitalization or the specific behaviors that are expected to interfere with a plan to transition the child/youth to a lower level of residential placement.
NOTE: Targeted Behavior(s) may also include specific behaviors that cause the child to be considered for an RCL 12 or above placement.
- **Clinical Judgment:** Include sufficient clinical information to demonstrate that TBS is necessary to sustain the residential placement, or to successfully transition the child/youth to a lower level of residential placement; and that TBS can be expected to provide a level of intervention necessary to stabilize the child/youth in the existing placement.
NOTE: Clinical Judgment may also include information that demonstrates that TBS is necessary to avoid psychiatric hospitalization or placement in an RCL 12 or higher group home.
- **Behavior Modification:** Identify observable and measurable changes and indicate when TBS services have been successful and could be reduced or terminated.
Adaptive Behaviors: Note identified skills and positive adaptive behaviors that the child/youth uses to manage the problem behavior and/or uses in other circumstances that could replace the specified problem behaviors.

Initial and on-going TBS assessments may be included a part of an overall assessment of a child or youth's mental health needs or may be a separate document specifically establishing whether initial/ongoing TBS is needed. If using the LACDMH paper forms, the initial and on-going TBS assessment are separate documents.

3. Thirty (30) Day Unplanned TBS Contact

The LACDMH may conditionally allow the provision of TBS for a maximum of 30 calendar days when class membership cannot be established for a child/youth. This may be done:

- Up to 30 days or until class membership is established, whichever comes first; or
- When the child/youth presents with an urgent or emergency conditions that jeopardize his/her current living arrangement.

4. Client Treatment Plan and Transition Plan

Any TBS recipient requires a written client treatment plan for TBS as part of the standard Client Treatment Plan for Specialty Mental Health Services (see Chapter 1). The following elements must be identified in the Client Treatment Plan for TBS to be provided:

Note: The standard Client Treatment Plan form may be used to document the following elements.

- **Targeted Behaviors:** Clearly identified specific behaviors that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS.
- **Plan Goals:** Specific, observable and quantifiable goals tied to the targeted behaviors.
NOTE: On the Client Treatment Plan, this would be the same as an objective.
- **Benchmarks:** The objectives to be met as the child/youth progresses towards achieving client plan goals.
- **Interventions:** Proposed intervention(s) expected to significantly diminish the targeted behaviors, including:
 - A specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan, which is developed with the family/caregiver, if available, and as appropriate.
 - A specific description of the changes in the behaviors that the interventions are intended to produce, including an estimated time frame for these changes.
 - A specific way to measure the effectiveness of the intervention at regular intervals and documentation of refining the intervention plan when the original interventions are not achieving expected results.
- **Transition Plan:** A transition plan that describes the method the treatment team will use to decide how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks have been reached or when reasonable progress towards goals/benchmarks is not occurring and, in the clinical judgment of the treatment team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers/school personnel with skills.
NOTE: The Transition Plan may be documented in a Progress Note so long as it is clearly identified as the "Transition Plan".
 - **Transitional Age Youth (TAY):** As necessary, includes a plan for transition to adult services when the beneficiary is no longer eligible for TBS and will

need continued services. This plan addresses assisting parents/caregivers with skills and strategies to provide continuity of care when TBS is discontinued, as appropriate in the individual case.

- If the beneficiary is between 18 and 21 years of age, include notes regarding any special considerations that should be taken into account.

5. Progress Notes

In addition to the Progress Note requirements set forth in Chapter 1, TBS progress notes should clearly document the occurrence of the specific behaviors that are the result of the covered mental health diagnosis which threaten the stability of the current placement or interfere with the transition to a lower level of residential placement, and the interventions provided to ameliorate those behaviors/symptoms.

A TBS progress note should exist for every TBS contact including:

- Direct one-to-one TBS service
- TBS Assessment and/or Reassessment
- TBS Collateral contact (see CCR Title 9 Section 1810.206)
- TBS Plan of Care/Client Plan or its documented review/updates

CHAPTER 3

Regulations and Requirements for Services Based on Blocks of Time (Mode 10)

SERVICE OVERVIEW & REIMBURSEMENT RULES

General Rules

TYPES OF SERVICES

Crisis Stabilization

Day Treatment Intensive (DTI)

Day Rehabilitation (DR)

Socialization Services

Vocational Services

SERVICE OVERVIEW & REIMBURSEMENT RULES

GENERAL RULES

The reimbursable unit for these services is client time reported in the DMH electronic data system and claimed in hours, four-hour increments, half days or full days. These services are bundled services and are not claimed by individual staff. Service time is determined by client time NOT staff time.

CRISIS STABILIZATION SERVICES

Definition (State Plan Amendment)

An unplanned, expedited service lasting less than 24 hours, to or on behalf of a client to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the client or others, or substantially increase the risk of the client becoming gravely disabled.

Service Components (State Plan Amendment)

Crisis Stabilization services include one or more of the following service components:

- Assessment
- Collateral
- Therapy
- Crisis Intervention
- Medication Support Services
- Referral

Frequency and Requirements of Documentation (State Contract)

For Crisis Stabilization, progress notes must be completed daily (one time per 23 hour period) and must include the elements identified in Chapter 1 Progress Notes.

Claiming (Mode, Service Function and Procedure Code Reference)

Crisis Stabilization services are claimed under Mode 10. Crisis Stabilization services include the following Service Function Codes:

- 24 – Crisis Stabilization (Emergency Room)
- 25 – Crisis Stabilization (Urgent Care Facility)

Refer to the Guide to Procedure Codes for a complete listing of procedure codes. Crisis Stabilization is a bundled service and is not claimed by individual staff. The Rendering Provider on the claim for Crisis Stabilization must be present on the day of service. The Rendering Provider may be the attending physician or staff writing the daily note (so long as all services described on the note are within scope of practice).

- Crisis Stabilization shall be reimbursed based on hours of time (CCR § 1840.322)
- Each one hour block that the client receives Crisis Stabilization services shall be claimed (CCR § 1840.322).
- Partial blocks of time shall be rounded up or down to the nearest one-hour increment except that services provided during the first hour shall always be rounded up (CCR § 1840.322).

Note: Client time spent in the waiting room is not service time.

Medi-Cal Lockouts

- ⇒ Crisis Stabilization is not reimbursable on days when Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services or Psychiatric Nursing Facility Services are reimbursed, except on the day of admission to those services (State Plan Amendment).
- ⇒ Crisis Stabilization is a package program and no other Specialty Mental Health Services are reimbursable during the same time period this service is reimbursed, except for Targeted Case Management (CCR § 1840.368)
- ⇒ The maximum number of hours claimable to Medi-Cal for Crisis Stabilization in a 24-hour period is 20 hours (State Plan Amendment).

Additional Requirements (State Plan Amendment unless otherwise noted)

In addition to the Documentation Requirements noted in Chapter 1, the following documentation and claiming rules apply:

- Must be provided on site at a licensed 24-hour health care facility, at a hospital based outpatient program (services in a hospital based outpatient program are provided in accordance with 42 CFR 440.20), or at a provider site certified by the Department of Health Care Services to perform Crisis Stabilization.
- Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies.

- Medications must be available on an as needed basis and the staffing pattern must reflect this availability.
- All clients receiving Crisis Stabilization must receive an assessment of their physical and mental health.
- A physician must be on call at all times for the provision of crisis stabilization services that must be provided by a physician.
- There shall be a minimum of one registered nurse, psychiatric technician, or licensed vocational nurse on site at all times clients are present. Other staff may be utilized by the program, according to need.
- At a minimum, there shall be a ratio of at least one licensed or waived/registered mental health professional on site for each four clients receiving Crisis Stabilization services at the same time.
- If a client is evaluated as needing service activities that may only be provided by a specific type of licensed professional, such a person must be available.
- If Crisis Stabilization services are co-located with other specialty mental health services, staff providing Crisis Stabilization must be separate and distinct from staff providing other services (CCR § 1840.348).
- Persons included in required Crisis Stabilization ratios and minimums may not be counted toward meeting ratios and minimums for other services (CCR § 1840.348).

DAY TREATMENT INTENSIVE

Day Treatment Intensive (State Plan Amendment)

Day Treatment Intensive service is a structured, multi-disciplinary program including community meetings, a therapeutic milieu, therapy, skill building groups, and adjunctive therapies, which provides services to a distinct group of individuals. It may also include rehabilitation, process groups and other interventions. Day Treatment Intensive is intended to provide an alternative to hospitalization, avoid placements in a more restrictive setting, or assist the client in living within a community setting. Services are available for at least three hours each day. The Day Treatment Intensive program is a program that lasts less than 24 hours each day.

Service Components (State Plan Amendment)

Day Treatment Intensive services must include the following service components:

- Community Meetings
- Therapeutic Milieu
- Process Groups (State Contract)
- Skill-Building Groups
- Adjunctive Therapies
- Psychotherapy

Day Treatment Intensive services may include one or more of the following service components:

- Assessment
- Plan Development
- Therapy
- Collateral
- Rehabilitation

Frequency and Requirements of Documentation

For Day Treatment Intensive, there must be daily progress notes and a weekly clinical summary. In addition to the required elements identified in Chapter 1 Progress Notes, the daily notes for Day Treatment Intensive must include:

- The total number of minutes/hours the client actually attended the program (State Contract)
- If the client was unavoidably absent and does not attend all of the scheduled hours of the Day Treatment Intensive program, there must be a separate entry that documents the reason for the unavoidable absence and the total time the client actually attended the program (State Contract).

The weekly clinical summary for Day Treatment Intensive must include:

- Dates of service within the time period covered by the note
- A summary describing what was attempted and/or accomplished toward the client's goals(s) by the client and service staff.
- Status of the client (symptoms, behaviors, impairments justifying continued Day Treatment Intensive services)
- Plan (should interventions be modified, do other behaviors need to be addressed)
- Staff signatures, discipline and licenses/registration number

NOTE: The weekly Clinical Summary must be reviewed and signed by a staff member who meets the qualifications of an AMHD.

NOTE: While there is no formal State requirement to have sign-in sheets, sign-in sheets may be used to show evidence the client was present. If sign-in sheets are used, it is recommended that they minimally include:

- Date
- Client name
- Client/responsible adult signature or staff documentation for lack of signature
- Time of arrival
- Staff name and signature/credentials verifying attendance

The presence of sign-in sheets does not negate the requirement for total duration of client presence within the program to be documented on each daily progress note.

Claiming (Mode, Service Function and Procedure Code Reference)

Day Treatment Intensive services are claimed under Mode 10. Day Treatment Intensive services include the following Service Function Codes:

- 85 – Day Treatment Intensive (Full Day)
- 82 – Day Treatment Intensive (Half Day)

Refer to the Guide to Procedure Codes for a complete listing of procedure codes which may be claimed as Day Treatment Intensive. Day Treatment Intensive is a bundled service and is not claimed by individual staff. The Rendering Provider on the claim for Day Treatment Intensive must be present on that day of service.

- The billing unit for Day Treatment Intensive is client time, based on full or half day blocks of time (CCR §1840.318).
- If a client is unavoidably absent and does not attend all of the scheduled hours of the Day Treatment Intensive program, Day Treatment Intensive services may only be claimed if the client is present at least 50% of scheduled hours of operation for that day (State Contract).
- A half day shall be claimed for each day in which the client receives face-to-face services in a program available four hours or less per day. Services must be available a minimum of three hours each day the program is open (CCR §1840.318).

NOTE: The client must receive face-to-face services on any full or half day claimed but all service activities provided that day are not required to be face-to-face (State Contract).

NOTE: Short breaks between activities are allowed. A lunch or dinner may also be appropriate depending on the program's schedule. However, these breaks shall not count towards the total hours of operation of the day program for purposes of determining minimum hours of service (State Contract).

- A full-day shall be claimed for each day in which the client receives face-to-face services in a program with services available more than four hours per day (CCR §1840.318).

- Medication Support Services that are provided within a Day Treatment Intensive program shall be billed separately from the Day Treatment Intensive programs (CCR §1840.326).

Medi-Cal Lockouts (CCR §1840.360)

- Day Treatment Intensive is not reimbursable when crisis residential treatment services, psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services are reimbursed except for the day of admission to those services.
- Mental Health Services are not reimbursable when provided by Day Treatment Intensive staff during the same time period that Day Treatment Intensive services are being provided.

Additional Requirements

Authorization Requirements (State Contract):

- Day Treatment Intensive services must be authorized by the Department prior to delivery and claiming.
- Day Treatment Intensive services must be re-authorized at least every three months.
- Mental Health Services (MHS) must be authorized when provided concurrently with Day Treatment Intensive services, excluding services to treat emergency and urgent conditions. MHS shall be authorized with the same frequency as the concurrent Day Treatment Intensive services.

Site Requirements (CCR §1840.328 and State Plan Amendment)

- Day Treatment Intensive services shall have a clearly established site for services, although all services need not be delivered at that site (CCR §1840.328).

Staffing Requirements:

- For Day Treatment Intensive, at least one staff person whose scope of practice includes psychotherapy (State Contract).
- Program staff may be required to spend time on Day Treatment Intensive activities outside the hours of operation and therapeutic milieu. (State Contract).

- At least one staff person must be present and available to the group in the therapeutic milieu for all scheduled hours of operation (State Contract)
- If Day Treatment Intensive staff have other responsibilities (e.g., as staff of a group home, a school or other mental health program), the Day Treatment Intensive programs must maintain documentation of the scope of responsibilities for these staff and the specific times in which Day Treatment Intensive activities are being performed exclusive of other activities (State Contract).
- Day Treatment Intensive programs serving more than twelve (12) clients must include staff from at least two of the staff categories listed in “Staffing Requirements for Day Treatment Programs” in the Appendix (CCR §1840.350).
- At a minimum there must be an average ratio of at least one staff to eight (8) clients in attendance during the period the program is open. Other staff may be utilized according to program need, but shall not be included as part of the ratio formula (CCR §1840.350). The staff categories that meet this requirement appear in the Appendix item, “Staffing Requirements for Day Treatment Programs.”

Program Requirements:

- In cases where absences are frequent, the need for the client to be in the Day Treatment Intensive program must be re-evaluated and appropriate action taken (State Contract).
- A written program description that describes the specific activities of each service and reflect each of the required components of the services (State Contract).
- An established protocol for responding to clients experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client’s urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the Day Treatment Intensive staff shall have the capacity to handle the crisis until the client is linked to an outside crisis service (State Contract).
- A detailed written weekly schedule identifying where and when the service components of the program will be provided and by whom shall be made available to clients and, as appropriate, to their families, caregivers, or significant support persons. The written weekly schedule shall specify the program staff, their qualifications, and the scope of their services (State Contract).

- At least one contact per month with a family member, caregiver or other significant support person identified by an adult client or one contact per month with the legally responsible adult for a client who is a minor. This contact may be face-to-face, by email, telephone or other method. Adult clients may decline this service component. The contact should focus on the role of the support person in supporting the client's community reintegration and shall occur outside the hours of operation and outside the therapeutic program for Day Treatment Intensive (State Contract).

DAY REHABILITATION

Day Rehabilitation (State Plan Amendment)

Day Rehabilitation is a structured program including rehabilitation, skill building groups, process groups, and adjunctive therapies which provides services to a distinct group of individuals. It may also include therapy, and other interventions. Day Rehabilitation is intended to improve or restore personal independence and functioning necessary to live in the community or prevent deterioration of personal independence consistent with the principles of learning and development. Services are available for at least three hours each day. Day Rehabilitation is a program that lasts less than 24 hours each day.

Service Components (State Plan Amendment)

Day Rehabilitation services must include the following service components:

- Community Meetings
- Therapeutic Milieu
- Process Groups (State Contract)
- Skill-Building Groups
- Adjunctive Therapies

Day Rehabilitation services may include one or more of the following service components:

- Assessment
- Plan Development
- Therapy
- Rehabilitation
- Collateral

Frequency and Requirements of Documentation

For Day Rehabilitation services, progress notes must be completed weekly, at a minimum. In addition to the elements identified in Chapter 1 Progress Notes, the weekly progress notes for Day Rehabilitation must include:

- Time period covered by the note
- Dates of service within the time period covered by the note
- The total number of minutes/hours the client actually attended the program for each date of service (State Contract)
- A summary describing what was attempted and/or accomplished toward the client's goals(s) by the client and service staff.
- If the client was unavoidably absent and does not attend all of the scheduled hours of the Day Rehabilitation program, there must be a separate entry that documents the reason for the unavoidable absence and the total time the client actually attended the program (State Contract).
- The signature of a staff member who provided services on each date of service. One signature may cover multiple dates of service for that staff.

NOTE: Each date of service must be accounted for by the signature of a staff member who actually provided services on that date (i.e. more than one staff member may be required to sign the weekly progress note in order to cover all dates of service within the time period covered by the note). One staff signature is sufficient to cover multiple dates the staff provided services.

NOTE: Staff completing the documentation must minimally meet the qualifications of a Mental Health Rehabilitation Specialist (MHRS).

NOTE: Programs may opt to use daily notes for Day Rehabilitation to document the dates of service during the week, the total duration the client was actually present each date of service, and the activities and interventions provided to the client. The use of daily notes does not negate the requirement for a weekly progress note that summarizes the week's activities/interventions and progress toward client goal(s).

NOTE: While there is no formal State requirement to have sign-in sheets, sign-in sheets may be used to show evidence the client was present. If sign-in sheets are used, it is recommended that they include at a minimum:

- Date
- Client name
- Client/responsible adult signature or staff documentation for lack of signature
- Time of arrival
- Staff name and signature/credentials verifying attendance

The presence of sign-in sheets does not negate the requirement for total duration of client presence within the program to be documented on each daily progress note.

Claiming (Mode, Service Function and Procedure Code Reference)

Day Rehabilitation services are claimed under Mode 10. Day Rehabilitation services include the following Service Function Codes:

- 98 – Day Rehabilitation (Full Day)
- 92 – Day Rehabilitation (Half Day)

Refer to the Guide to Procedure Codes for a complete listing of procedure codes and disciplines which may be claimed as Day Rehabilitation. Day Rehabilitation is a bundled service and is not claimed by individual staff. The Rendering Provider on the claim for Day Rehabilitation must be present on that day of service.

- The billing unit for Day Rehabilitation is client time, based on full or half days.
- If a client is unavoidably absent and does not attend all of the scheduled hours of the Day Rehabilitation program, Day Rehabilitation services may only be claimed if the client is present at least 50% of scheduled hours of operation for that day.
- A half day shall be claimed for each day in which the client receives face-to-face services in a program available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

NOTE: The client must receive face-to-face services on any full or half day claimed but all service activities provided that day are not required to be face-to-face.

NOTE: Short breaks between activities are allowed. A lunch or dinner may also be appropriate depending on the program's schedule. However, these breaks shall not count towards the total hours of operation of the day program for purposes of determining minimum hours of service (State Contract).

- A full-day shall be claimed for each day in which the client receives face-to-face services in a program with services available more than four hours per day.
- Medication Support Services that are provided within a Day Rehabilitation program shall be billed separately from the Day Rehabilitation programs (CCR §1840.326)

Medi-Cal Lockouts (CCR §1840.360)

- Day Rehabilitation services are not reimbursable when crisis residential treatment services, psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services are reimbursed except for the day of admission to those services.
- Mental Health Services are not reimbursable when provided by Day Rehabilitation staff during the same time period that Day Rehabilitation services are being provided.

Additional Requirements

Authorization Requirements (State Contract):

- Day Rehabilitation services must be authorized by the Department prior to delivery and claiming.
- Day Rehabilitation services must be re-authorized at least every six months.
- Mental Health Services must be authorized when provided concurrently with Day Rehabilitation services, excluding services to treat emergency and urgent conditions. Mental Health Services shall be authorized with the same frequency as the concurrent Day Rehabilitation services.

Staffing Requirements:

- Program staff may be required to spend time on Day Rehabilitation activities outside the hours of operation and therapeutic milieu (State Contract).
- At least one staff person must be present and available to the group in the therapeutic milieu for all scheduled hours of operation (State Contract).
- If Day Rehabilitation staff have other responsibilities (e.g., as staff of a group home, a school or other mental health program), the Day Rehabilitation programs must maintain documentation of the scope of responsibilities for these staff and the specific times in which Day Rehabilitation activities are being performed exclusive of other activities (State Contract).
- At a minimum there must be an average ratio of at least one staff to ten (10) clients in attendance during the period the program is open. Other staff may be utilized according to program need, but shall not be included as part of the ratio formula (CCR §1840.350). The staff categories that meet this requirement appear in the Appendix item, "Staffing Requirements for Day Treatment Programs."
- Day Rehabilitation programs serving more than twelve (12) clients must include two staff identified in "Staffing Requirements for Day Treatment Programs" (See Appendix). (CCR §1840.352).

Program Requirements:

- In cases where absences are frequent, the need for the client to be in the Day Rehabilitation program must be re-evaluated and appropriate action taken (State Contract).

- A written program description that describes the specific activities of each service and reflects each of the required components of the services (State Contract).
- At least one contact per month with a family member, caregiver or other significant support person identified by an adult client or one contact per month with the legally responsible adult for a client who is a minor. This contact may be face-to-face, by email, telephone or other method. Adult clients may decline this service component. The contact should focus on the role of the support person in supporting the client's community reintegration and shall occur outside the hours of operation and outside the therapeutic program for Day Rehabilitation (State Contract).

S O C I A L I Z A T I O N D A Y S E R V I C E S

Socialization Day Services (CCR §542)

Services designed to provide activities for persons who require structured support and the opportunity to develop the skills necessary to move toward more independent functioning. The services in this program include outings, recreational activities, cultural events, linkages to community resources, and other rehabilitation efforts. Services are provided to persons who might otherwise lose contact with a social or treatment system.

Frequency and Requirements of Documentation

For Socialization Day services, progress notes must be completed weekly. In addition to the elements identified in Chapter 1 Progress Notes, the weekly note for Socialization Day Services must include:

- Time period covered by the note
- Dates of service within the time period covered by the note
- The total number of blocks of time delivered for each date of service
- The activities in which the client participated
- A summary describing what was attempted and/or accomplished toward the client's goal(s) by the client and service staff
- The current functional level of the client
- The current functional impairment of the client

Claiming (Mode, Service Function and Procedure Code Reference)

Socialization Day services are claimed under Mode 10. Socialization Day services include the following Service Function Code:

- 41 – Socialization Day Service

Refer to the Guide to Procedure Codes for a complete listing of procedure codes and disciplines which may be claimed as Socialization Day Services. Socialization Day

Services is a bundled service and is not claimed by individual staff. The Rendering Provider on the claim for Socialization Day Services must be present on the day of service.

- The billing unit for Socialization Day Services is client time, based on four hour blocks of time.

Medi-Cal Lockouts

- Socialization Day Services may never be claimed to Medi-Cal.

Additional Requirements

- Less than or equal to four hours is one block of time. Greater than four hours and up to eight hours is two blocks of time. Greater than eight hours and up to twelve hours is three blocks of time.
- No more than three blocks of time may be claimed in a day.
- Costs for documentation are included in the rate for these services and shall not be separately billed.

V O C A T I O N A L D A Y S E R V I C E S

Vocational Day Services

This bundled service is designed to encourage and facilitate individual motivation and focus upon realistic and attainable vocational goals. To the extent possible, the intent of these services is to maximize individual client involvement in skill seeking enhancement with an ultimate goal of self-support. These vocational services shall be bundled into a milieu program for chronically and persistently mentally ill clients who are unable to participate in competitive employment.

The program stresses development of sound work habits, skills, and social functioning for marginally productive persons who ultimately may be placed in work situations ranging from sheltered work environments to part or full-time competitive employment.

Frequency and Requirements of Documentation

For Vocational Day Services, progress notes must be completed weekly. In addition to the elements identified in Chapter 1 Progress Notes, the weekly progress notes for Vocational Day Services must include:

- Time period covered by the note

- Dates of service within the time period covered by the note
- The total number of blocks of time delivered for each date of service
- The activities in which the client participated
- A summary describing what was attempted and/or accomplished toward the client's goal(s) by the client and service staff
- The current functional level of the client
- The current functional impairment of the client

Claiming (Mode, Service Function and Procedure Code Reference)

Vocational Day services are claimed under Mode 10. Vocational Day services include the following Service Function Codes:

- 31 – Vocational Day Service

Refer to the Guide to Procedure Codes for a complete listing of procedure codes and disciplines which may be claimed as Vocational Day Services. Vocational Day Services is a bundled service and is not claimed by individual staff. The Rendering Provider on the claim for Vocational Day Services must be present on the day of service.

- The billing unit for Vocational Day Services is client time, based on four hour blocks of time.

Medi-Cal Lockouts

- Vocational Day Services may never be claimed to Medi-Cal.

Additional Requirements

- Less than or equal to four hours is one block of time. Greater than four hours and up to eight hours is two blocks of time. Greater than eight hours and up to twelve hours is three blocks of time.
- No more than three blocks of time may be claimed in a day.
- Costs for documentation are included in the rate for these services and shall not be separately billed.

MEDI-CAL INCLUDED OUTPATIENT AND DAY SERVICE ICD-10-CM DIAGNOSIS

F200	Paranoid schizophrenia	F3176	Bipolar disorder, in full remis, most recent episode depress
F201	Disorganized schizophrenia	F3177	Bipolar disord, in partial remis, most recent episode mixed
F202	Catatonic schizophrenia	F3178	Bipolar disorder, in full remis, most recent episode mixed
F203	Undifferentiated schizophrenia	F3181	Bipolar II disorder
F205	Residual schizophrenia	F3189	Other bipolar disorder
F2081	Schizophreniform disorder	F319	Bipolar disorder, unspecified
F209	Schizophrenia, unspecified	F320	Major depressive disorder, single episode, mild
F21	Schizotypal disorder	F321	Major depressive disorder, single episode, moderate
F22	Delusional disorders	F322	Major depressv disord, single epsd, sev w/o psych features
F23	Brief psychotic disorder	F323	Major depressv disord, single epsd, severe w psych features
F24	Shared psychotic disorder	F324	Major depressv disorder, single episode, in partial remis
F250	Schizoaffective disorder, bipolar type	F325	Major depressive disorder, single episode, in full remission
F251	Schizoaffective disorder, depressive type	F328	Other depressive episodes
F258	Other schizoaffective disorders	F329	Major depressive disorder, single episode, unspecified
F259	Schizoaffective disorder, unspecified	F330	Major depressive disorder, recurrent, mild
F28	Other psychotic disorder not due to a substance or known physiological condition	F331	Major depressive disorder, recurrent, moderate
F29	Unspecified psychosis not due to a substance or known physiological condition	F332	Major depressv disorder, recurrent severe w/o psych features
F3010	Manic episode without psychotic symptoms, unspecified	F333	Major depressv disorder, recurrent, severe w psych symptoms
F3011	Manic episode without psychotic symptoms, mild	F33.40	Major depressive disorder, recurrent, in remission, unsp
F3012	Manic episode without psychotic symptoms, moderate	F3341	Major depressive disorder, recurrent, in partial remission
F3013	Manic episode, severe, without psychotic symptoms	F3342	Major depressive disorder, recurrent, in full remission
F302	Manic episode, severe with psychotic symptoms	F338	Other recurrent depressive disorders
F303	Manic episode in partial remission	F339	Major depressive disorder, recurrent, unspecified
F304	Manic episode in full remission	F340	Cyclothymic disorder
F308	Other manic episodes	F341	Dysthymic disorder
F30.9	Manic episode, unspecified	F348	Other persistent mood [affective] disorders
F3110	Bipolar disord, crnt episode manic w/o psych features, unsp	F349	Persistent mood [affective] disorder, unspecified
F3111	Bipolar disord, crnt episode manic w/o psych features, mild	F39	Unspecified mood [affective] disorder
F3112	Bipolar disord, crnt episode manic w/o psych features, mod	F4000	Agoraphobia, unspecified
F3113	Bipolar disord, crnt epsd manic w/o psych features, severe	F4001	Agoraphobia with panic disorder
F312	Bipolar disord, crnt episode manic severe w psych features	F4002	Agoraphobia without panic disorder
F3130	Bipolar disord, crnt epsd depress, mild or mod severt, unsp	F4010	Social phobia, unspecified
F3131	Bipolar disorder, current episode depressed, mild	F4011	Social phobia, generalized
F3132	Bipolar disorder, current episode depressed, moderate	F40210	Arachnophobia
F314	Bipolar disord, crnt epsd depress, sev, w/o psych features	F40218	Other animal type phobia
F315	Bipolar disord, crnt epsd depress, severe, w psych features	F40220	Fear of thunderstorms
F3160	Bipolar disorder, current episode mixed, unspecified	F40228	Other natural environment type phobia
F3161	Bipolar disorder, current episode mixed, mild	F40230	Fear of blood
F3162	Bipolar disorder, current episode mixed, moderate	F40231	Fear of injections and transfusions
F3163	Bipolar disord, crnt epsd mixed, severe, w/o psych features	F40232	Fear of other medical care
F3164	Bipolar disord, crnt episode mixed, severe, w psych features	F40233	Fear of injury
F3170	Bipolar disord, currently in remis, most recent episode unsp	F40240	Claustrophobia
F3171	Bipolar disorder, in partial remis, most recent epsd hypomanic	F40241	Acrophobia
F3172	Bipolar disorder, in full remis, most recent episode hypomanic	F40242	Fear of bridges
F3173	Bipolar disorder, in partial remis, most recent episode manic	F40243	Fear of flying
F3174	Bipolar disorder, in full remis, most recent episode manic	F40248	Other situational type phobia
F3175	Bipolar disorder, in partial remis, most recent epsd depress	F40290	Androphobia

MEDI-CAL INCLUDED OUTPATIENT AND DAY SERVICE ICD-10-CM DIAGNOSIS (continued)

F40291	Gynephobia	F6381	Intermittent explosive disorder
F40298	Other specified phobia	F639	Impulse disorder, unspecified
F408	Other phobic anxiety disorders	F641	Gender identify disorder in adolescence and adulthood
F410	Panic disorder without agoraphobia	F642	Gender identify disorder in childhood
F411	Generalized anxiety disorder	F649	Gender identify disorder, unspecified
F413	Other mixed anxiety disorders	F650	Fetishism
F418	Other specified anxiety disorders	F651	Transvestic fetishism
F419	Anxiety disorder, unspecified	F652	Exhibitionism
F42	Obsessive-compulsive disorder	F653	Voyeurism
F430	Acute stress reaction	F654	Pedophilia
F4310	Post-traumatic stress disorder, unspecified	F6550	Sadomasochism, unspecified
F4311	Post-traumatic stress disorder, acute	F6551	Sexual masochism
F4312	Post-traumatic stress disorder, chronic	F6552	Sexual sadism
F4320	Adjustment disorder, unspecified	F6581	Frotteurism
F4321	Adjustment disorder with depressed mood	F659	Paraphilia, unspecified
F4322	Adjustment disorder with anxiety	F6810	Factitious disorder, unspecified
F4323	Adjustment disorder with mixed anxiety and depressed mood	F6811	Factitious disorder with predominantly psychological signs and symptoms
F4324	Adjustment disorder with disturbance of conduct	F6812	Factitious disorder with predominantly physical signs and symptoms
F4325	Adjustment disorder w mixed disturb of emotions and conduct	F6813	Factitious disorder with combined psychological and physical signs and symptoms
F440	Dissociative amnesia	F842	Rett's syndrome
F441	Dissociative fugue	F843	Other childhood disintegrative disorder
F444	Conversion disorder with motor symptom or deficit	F845	Asperger's syndrome
F445	Conversion disorder with seizures or convulsions	F848	Other pervasive developmental disorders
F446	Conversion disorder with sensory symptom or deficit	F849	Pervasive developmental disorder, unspecified
F447	Conversion disorder with mixed symptom presentation	F900	Attention-deficit hyperactivity disorder, predominantly inattentive type
F4481	Dissociative identity disorder	F901	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F449	Dissociative and conversion disorder, unspecified	F902	Attention-deficit hyperactivity disorder, combined type
F450	Somatization disorder	F90.9	Attention-deficit/hyperactivity disorder, unspecified type
F451	Undifferentiated somatoform disorder	F911	Conduct disorder, childhood-onset type
F4522	Body dysmorphic disorder	F912	Conduct disorder, adolescent-onset type
F4541	Pain disorder exclusively related to psychological factors	F913	Oppositional defiant disorder
F4542	Pain disorder with related psychological factors	F919	Conduct disorder, unspecified
F458	Other somatoform disorders	F930	Separation anxiety disorder of childhood
F481	Depersonalization-derealization syndrome	F938	Other childhood emotional disorders
F5000	Anorexia nervosa, unspecified	F939	Childhood emotional disorder, unspecified
F5001	Anorexia nervosa, restricting type	F940	Selective mutism
F5002	Anorexia nervosa, binge eating/purging type	F941	Reactive attachment disorder of childhood
F502	Bulimia nervosa	F980	Enuresis not due to a substance or known physiol condition
F509	Eating disorder, unspecified	F981	Encopresis not due to a substance or known physiol condition
F600	Paranoid personality disorder	F9821	Rumination disorder of infancy
F601	Schizoid personality disorder	F9829	Other feeding disorders of infancy and early childhood
F603	Borderline personality disorder	F983	Pica of infancy and childhood
F604	Histrionic personality disorder	F98.4	Stereotyped movement disorders
F605	Obsessive-compulsive personality disorder	G210	Malignant neuroleptic syndrome
F606	Avoidant Personality Disorder	G2111	Neuroleptic induced parkinsonism
F607	Dependent personality disorder	G244	Idiopathic orofacial dystonia
F6081	Narcissistic personality disorder	G251	Drug-induced tremor
F609	Personality disorder, unspecified	G2570	Drug-induced movement disorder, unspecified
F630	Pathological gambling	G2571	Medication-induced acute akathisia
F631	Pyromania	G25.9	Extrapyramidal and movement disorder, unspecified
F632	Kleptomania	R150	Incomplete defecation
F633	Trichotillomania	R159	Full incontinence of feces

CHAPTER 5

Regulations and Requirements for Services Based on Calendar Days

GENERAL RULES

**ADULT RESIDENTIAL TREATMENT SERVICES
(Transitional and Long-Term)**

CRISIS RESIDENTIAL TREATMENT SERVICES

PSYCHIATRIC HEALTH FACILITY

GENERAL RULES

Service Reimbursement by Calendar Days (§1840.320):

This applies to:

- ⇒ Adult Residential Treatment Services (Transitional and Long-Term)
- ⇒ Crisis Residential Treatment Services
- ⇒ Psychiatric Health Facility Services

Claiming Rules (§1840.320):

- ⇒ A day shall be billed for each calendar day in which the client receives face-to-face services and the client has been admitted to the program. Services may not be billed for the days the client is not present.
- ⇒ Board and Care costs are not included in the claiming rate (also §1840.312).
- ⇒ The day of admission may be billed but not the day of discharge.

Minimum Documentation Requirements:

(See also Chapter 1, “General Documentation Rules”)

- ⇒ Date(s) of Service
- ⇒ Procedure Code
- ⇒ Written assessment upon admission that includes (LAC-DMH Policy 104.9):
 - health and psychiatric histories;
 - psychosocial skills;
 - social support skills;
 - current psychological, educational, vocational and other functional limitations;
 - medical needs, as reported; and
 - meal planning, shopping, and budgeting skills.
- ⇒ The notes shall address (LAC-DMH Policy 104.9):
 - Activities in which the client participated
 - Client's behaviors and staff intervention
 - Progress toward objectives or documentation of lack of progress
 - Involvement of family members if appropriate
 - Contact with other programs/agencies/treatment personnel involved with the client's treatment.
- ⇒ There shall be notes for all staff involved in the client's treatment.
- ⇒ For Crisis Residential and Transitional and Long-Term Residential services:
 - There shall be a note whenever a scheduled session takes place with the client.
 - There shall be a note indicating the activities in which the client participated.

Signature Requirements:

(See Chapter 1, “Signature Requirements.”)

<p style="text-align: center;">ADULT RESIDENTIAL TREATMENT SERVICES (Transitional and Long Term)</p>
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Definition (§1810.203):

Rehabilitation services provided in a non-institutional residential setting which provide a therapeutic community including a range of activities and services for clients who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service is available 24 hours a day, seven days a week.

Service Activities:

Services shall be consistent with §532 of Title 9, California Code of Regulations. Service activities may include Assessment, Plan Development, Therapy, Rehabilitation and Collateral (§1810.203).

NOTE:

- Not all of these activities need to be provided for the service to be billable.
- Medication Support Services shall be billed separately from Adult Residential Treatment Services [§1840.326(b)].

The codes for claiming are according to type of residential program. Please see "Guide to Procedure Codes" for the appropriate code(s), code modifiers, and place of service codes for:

- Transitional Residential - Transitional
- Transitional Residential - Long Term

Site and Contact Requirements (§1840.332):

There is a clearly established certified site for services although all services need not be delivered at that site. Services shall not be billable unless there is face-to-face contact on the day of service and the client has been admitted to the program.

Programs providing Adult Residential Treatment Services must be certified as a Social Rehabilitation Program by the State Department of Mental Health as either a Transitional Residential Treatment Program or a Long Term Residential Treatment Program. Facility capacity must be limited to a maximum of 16 beds.

In addition to Social Rehabilitation Program certification, programs providing Adult Residential Treatment Services must be licensed as a Social Rehabilitation Facility or Community Care Facility by the Department of Social Services or authorized to operate as a Mental Health Rehabilitation Center by the State Department of Mental Health.

Lockouts (§1840.362):

Adult Residential Treatment Services are not reimbursable on days when Crisis Residential Treatment Services, Inpatient Services, or Psychiatric Health Facility or Psychiatric Nursing Facility Services are reimbursed, except for the day of admission.

Providers may not allocate the same staff's time under the two cost centers of Adult Residential and Mental Health Services for the same period of time.

Frequency of Documentation:

At least a weekly summary and a separate note whenever a scheduled session takes place with the client.

Staffing Ratio and Staff Qualifications (§1840.354):

Staffing ratios and qualifications in Adult Residential Treatment Services shall be consistent with Title 9, §531 (see Appendix).

There shall be a clear audit trail of the number and identity of the persons who provide Adult Residential Treatment Services and function in other capacities.

CRISIS RESIDENTIAL TREATMENT SERVICES**Definition (§1810.208):**

“Crisis Residential Treatment Service” means therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program for clients as an alternative to hospitalization for clients experiencing an acute psychiatric episode or crisis who do not present medical complications requiring nursing care. The service supports clients in their efforts to restore, maintain and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week.

Service Activities:

Services shall be consistent with §532 of Title 9, CCR (see Appendix).

Service activities include assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention (§1810.208).

NOTE:

- Not all of these activities need to be provided for the service to be billable.
- Medication Support Services shall be billed separately from Adult Residential Treatment Services [§1840.326(b)].

Site and Contact Requirements (§1840.334):

There is a clearly established certified site for services although all services need not be delivered at that site. Services shall not be billable unless there is face-to-face contact on the day of service and the client has been admitted to the program.

Programs shall have written procedures for accessing emergency psychiatric and health services on a 24-hour basis.

Programs providing Crisis Residential Treatment Services must be certified as a Social Rehabilitation Program (Short-Term Crisis Residential Treatment Program) by the State Department of Mental Health. Facility capacity must be limited to a maximum of 16 beds.

In addition to Social Rehabilitation Program certification, programs providing Crisis Residential Treatment Services must be licensed as a Social Rehabilitation Facility or Community Care Facility by the State Department of Social Services or authorized to operate as a Mental Health Rehabilitation Center by the State Department of Mental Health.

Lockouts (§1840.364):

Crisis Residential Treatment Services are not reimbursable on days when the following services are reimbursed, except for day of admission to Crisis Residential Treatment Services:

- Mental Health Service
- Day Treatment Intensive
- Day Rehabilitation
- Inpatient Services
- Psychiatric Health Facilities Services
- Psychiatric Nursing Facility Services
- Adult Residential Treatment Services
- Crisis Intervention
- Crisis Stabilization

Frequency of Documentation:

There shall be a daily note for each day the client is in the program (LAC-DMH Policy 104.9); (SDMH Contract, Exhibit A, Attachment 1, Appendix C).

Staffing Ratio and Staff Qualifications (§1840.356):

Staffing ratios and qualifications in Crisis Residential Treatment Services shall be consistent with CCR, Title 9, §531 (See Appendix).

PSYCHIATRIC HEALTH FACILITY

Definition (§1810.236):

A “Psychiatric Health Facility” is licensed by the State Department of Mental Health under the provisions of Chapter 9, Division 5 of Title 22 as providers of inpatient hospital services and will be governed by the provisions applicable to hospitals and psychiatric inpatient hospital services, except when specifically indicated in context.

Services (§1810.237):

Psychiatric Health Facility Services are therapeutic and/or rehabilitation services provided in a non-hospital 24-hour inpatient setting, on either a voluntary or involuntary basis. Services are provided to clients who need acute care and whose physical health needs can be met in an affiliated hospital or in outpatient settings. The determination for the need for acute care shall be made in accordance with §1820.205 (see Appendix item, “Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services”).

Site and Contact Requirements (§1840.340):

There is a clearly established certified site for services. Services shall not be billable unless there is face-to-face contact on the day of service and the client has been admitted to the program.

Programs providing Psychiatric Health Facility Services must be licensed as a Psychiatric Health Facility by the State Department of Mental Health under the provisions of Chapter 9, Division 5 of Title 22 (§1810.236).

Programs shall have written procedures for accessing emergency health services on a 24 hour basis.

Lockouts (§1840.370):

The following services are not reimbursable on days when Psychiatric Health Facility Services are reimbursed, except for day of admission to Psychiatric Health Facility Services:

- Adult Residential Treatment Services
- Crisis Residential Treatment Services
- Crisis Intervention
- Day Treatment Intensive
- Day Rehabilitation
- Inpatient Services
- Medication Support Services
- Mental Health Services
- Crisis Stabilization - Emergency Room
- Crisis Stabilization - Urgent Care
- Psychiatric Nursing Facility Services

Minimum Documentation Requirements:

(See also, Chapter 1, “General Documentation Rules”, and “Minimum Documentation Requirements” at the beginning of this Chapter.)

Date of Service and shift

A description of service provided.

Interdisciplinary Treatment Plan within 72 hours following admissions (Saturdays, Sundays, and holidays excepted), consistent with requirements described in §77073 of Title 22, CCR, (See Appendix).

Frequency of Documentation:

A note on each shift

Staffing Ratios and Staff Qualifications (§1840.358):

Staffing ratios in Psychiatric Health Facility Services shall be consistent with §77061 of Title 22, CCR (see Appendix).

Staffing qualifications shall be consistent with Sections 77004, 77011.2, 77012, 77012.1, 77012.2, 77017, 77023, 77059-77069, 77079.1 and 77079.12, of Title 22, CCR (see Appendix).

A clear audit trail must be maintained for staff who function as Psychiatric Health Facility Services staff and in other capacities.

CHAPTER 6

Definitions

DEFINITIONS

(arranged alphabetically)

ACADEMIC EDUCATIONAL SERVICE

Non-Medi-Cal reimbursable educational activities in which the focus is on learning information for the purpose of furthering one's scholastic ability.

ADOLESCENT

A minor aged 12 through 18; adolescents receiving AB 3632 services are included through age 22, and in some instances may be up to age 25. This Client may participate in planning activities and sign his/her Client Care/Coordination Plan, at the discretion of the service provider and family. A minor, age 12 through 18 may consent to his/her own services, with the exception of medication, if s/he meets all of the criteria as specified on the "Consent of Minor" form.

ADULT RESIDENTIAL TREATMENT SERVICE (AdRes)

(See Chapter 5, *Regulations and Requirements for Services Based on Calendar Days, Adult Residential Services*)

ASSESSMENT

[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Mental Health Services, Assessment (A)*]

BACHELOR'S DEGREE IN MENTAL HEALTH RELATED FIELD

A bachelor's degree in a mental health related field means that the service delivery staff person, in lieu of a license, has received a baccalaureate degree in a discipline that may include child development, child psychology, counseling and guidance, counseling psychology, early childhood education, human services, social psychology, social science, social welfare, social work, or sociology. Other disciplines may be approved by the local mental health director if she/he determines that such curriculums have mental health application.

BARRIERS TO REACHING GOALS

This is the second element on the Client Care/Coordination Plan (see also "Desired Outcomes/Long-Term Goals). A combination of the client's self-awareness and observations of service delivery staff may be the identified obstacles for the client to achieving his/her Long-Term Goals

BENEFICIARY (§1810.205)

Any person certified as eligible under the Medi-Cal Program according to Title 22, Section 51001.

CASE MANAGEMENT/BROKERAGE – See TARGETED CASE MANAGEMENT**CERTIFIED MENTAL HEALTH REHABILITATION PROGRAM**

A certified provider where Medi-Cal services occur under the federal programs of Rehabilitation Option or Targeted Case Management.

CHILD

A minor under the age of 12 receiving services. This Client may participate in planning activities and sign his/her Client Care/Coordination Plan, at the discretion of the service provider and family. A minor under the age of 12 may never consent for their own services.

CLAIMING (§1840.100)

The process by which MHPs may obtain FFP (Federal Financial Participation) for the expenditures they have made for specialty mental health services to Medi-Cal clients.

CLIENT

The term most commonly used by the LAC-DMH when referring to a consumer of services, regardless of payer. .

CLIENT CARE/COORDINATION PLAN (CCCP)

(See Chapter 1, *Service, Documentation, and Reimbursement Basics, Client Care/Coordination Plan*)

CLINICAL RECORD/CHART

The case record for a client that documents all services delivered to a client within a Provider. It provides a record of services for clinical continuity of care and is the audit trail for all claims.

COLLATERAL (Col) (also see SIGNIFICANT SUPPORT PERSONS)

[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Mental Health Services, Collateral*]

COORDINATION CYCLE DATE

For clients new to the system and those without open episodes, it is the date of admission, e.g., 05/14/04. For successive year it will be the first day of the month of intake, e.g., 05/01/05. For clients with open episodes anywhere within the system, it is the cycle date established by the current Coordinator/SFPR

COORDINATION PLAN – See CLIENT CARE/COORDINATION PLAN

COORDINATOR

Also known as the Single Fixed Point of Responsibility (SFPR). This person or team provides the primary point of coordination for a client, as identified in LAC-DMH's Information System (IS). The Coordinator is responsible for developing the Client Care/Coordination Plan with the Client and approving Client Care/Coordination Plans for any Mental Health Services, Day Treatment, Day Rehabilitation, and Adult Residential services proposed by any provider in the LAC-MHP system of care. Once established, a staff person or team remains a client's Coordinator/SFPR even when all episodes are closed or the client is not participating in services until the responsibility is transferred to another staff person.

CRISIS INTERVENTION (CI)

[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Crisis Intervention*]

CRISIS RESIDENTIAL TREATMENT FACILITY (CrRes)

(See Chapter 5, *Regulations and Requirements for Services Based on Calendar Days, Crisis Residential Treatment Services*)

CRISIS STABILIZATION (CS)

[See Chapter 4, *Regulations and Requirements for Services Based on Blocks of Time (Mode 10), Medi-Cal Reimbursable Services, Hours of Time, Crisis Stabilization Services*]

CULTURAL COMPETENCE (§1810.211)

“Cultural Competence” means a set of congruent practice skills, behaviors, attitudes, and policies in a system, agency, or among persons providing services that enables that system, agency, or those persons providing services to work effectively in cross cultural situations.

CYCLE PERIOD

For services after the initial Client Care/Coordination Plan (CCCP), the cycle period is the timeframe for developing subsequent Client Care Plans. For CalWORKs, this includes not only the CCCP but also the CalWORKS Client Employment Plan. CalWORKS cycle periods are every three months; for Targeted Case Management (TCM) and Medication Support (Meds or MSS), the cycle period is annual. For all other services, the cycle period is every six months and annually. The Client Care/Coordination Plan must align with the cycle date (see Coordination Cycle Date).

Example of the cycle period for a client whose date of intake is 05/14/04:

- The initial CCCP is due at the time of or close to the completion of the intake assessment, but no later than 07/13/04 (60 days from the date of example above).
- For subsequent CCCPs:
 - CalWorks – within the month prior to 8/1/04, 11/1/04, 2/1/05, and 5/1/05
 - All services except Meds & TCM – within the month prior to 11/1/04 & 5/1/05
 - All services including MSS and TCM – within the month prior to 05/1/05

DAY REHABILITATION (DR)

[See Chapter 4, *Regulations and Requirements for Services Based on Blocks of Time (Mode 10), Medi-Cal Reimbursable Services, Half or Full-Days of Time, Day Rehabilitation*]

DAY TREATMENT INTENSIVE (DTI)

[See Chapter 4, *Regulations and Requirements for Services Based on Blocks of Time (Mode 10), Medi-Cal Reimbursable Services, Half or Full-Days of Time, DayTreatment Intensive*]

DESIRED OUTCOME/LONG-TERM GOAL

This is the first element in the Client Care/Coordination Plan. In the words of the client and, for minors, the responsible adult, this is a statement of what the client wants to accomplish with the assistance of mental health services within the next 12 months.

DURATION OF SERVICE

The amount of time it takes to deliver the services, including travel and documentation.

EMERGENCY PSYCHIATRIC CONDITION (§1810.216)

A condition that meets the criteria in §1820.205 (Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services) and when the client with a condition, due to a mental disorder, is a danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services.

FACE-TO-FACE TIME

See “TYPES OF TIME” below.

FEE-FOR-SERVICE/MEDI-CAL

California’s Medicaid program that provides reimbursement for a broad array of health and limited mental health services provided to Clients who are eligible for Medi-Cal.

FREEDOM OF CHOICE

Local mental health programs shall inform Clients receiving services under the Rehabilitation Option, including parents or guardians of children/adolescents, verbally or in writing that:

- A. Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;
- B. They retain the right to access other Medi-Cal or Short-Doyle/Medi-Cal reimbursable services and have the right to request a change of provider and/or staff person/therapist/case manager.

FUNCTIONAL IMPAIRMENT

A dysfunction caused by a person’s mental illness in an important area of life functioning, such as living situation, daily activities, or social support.

GROUP (Gr)

[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Mental Health Services, Group Service.*]

HEAD OF SERVICE (CCR, Title 9, §622)

Each provider shall have a head of service in conformance with one of the following staff categories recognized by the Los Angeles County Mental Health Plan.

Psychiatrist (CCR, Title 9 §623)

Psychiatrist means a person possessing a valid license as physician and surgeon from the Medical Board of California and evidence of completion of the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program of training accredited by the American Medical Association or the American Osteopathic Association.

Psychologist (CCR, Title 9 §624)

Psychologist means a person possessing a valid license as a clinical psychologist granted by the Medical Board of California unless exempt or waived under the provisions of Welfare and Institutions Code, Section 5751.2; and shall have two (2) years post-doctoral experience in a mental health setting.

Licensed Clinical Social Worker (CCR, Title 9 §625)

Social Worker means a person possessing a valid license as a clinical social worker granted by the California Board of Behavioral Science Examiners unless exempt or registered/waived under the provisions of Welfare and Institutions Code, Section 5751.2; and shall have two (2) years post master's experience in a mental health setting.

Marriage & Family Therapist (CCR, Title 9 §626)

Marriage, Family, and Child Counselor means a person possessing a valid license as a marriage, family, and child counselor granted by the California Board of Behavioral Science Examiners; or who has been registered/waived under the provisions of Welfare and Institutions Code, Section 5751.2; and shall have two (2) years post master's experience in a mental health setting.

Registered Nurse (CCR, Title 9 §627)

Registered Nurse means a person possessing a valid license to practice as a registered nurse granted by the California Board of Registered Nursing and a master's degree in psychiatric or public health nursing, and two years of nursing experience in a mental health setting. Additional post baccalaureate nursing experience in a mental health setting may be substituted on a year-for-year basis for the education requirement.

INTAKE PERIOD (LAC-DMH Policy No. 104.9)

Initial clinical evaluations must be completed within 60 days of intake for a new admission (no open episodes), or within 30 days when the client is being opened to a new service but has other open episodes.

INSTITUTION FOR MENTAL DISEASE (§1810.222.1)

A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental illness, including medical attention, nursing care, and related services.

LEGAL ENTITY (CCR, Title 9, §1840.100)

Each MHP and each of the corporations, partnerships, agencies, or individuals providing specialty mental health services under contract with the MHP, except that legal entity does not include individual or group providers, Fee-For-Service/Medi-Cal hospitals or psychiatric nursing facilities.

LICENSED CLINICAL SOCIAL WORKER (LCSW)

A person with a license to practice as a clinical social worker granted by the State Board of Behavioral Science Examiners. A licensed clinical social worker candidate who is registered or waived may assume certain roles and responsibilities of a licensed clinician, within scope of practice; e.g., provide therapy and develop and sign Client Care/Coordination Plans. Registered/waivered staff may document in the clinical record without co-signatures.

LICENSED VOCATIONAL NURSE (LVN)

A person with a license to practice vocational nursing granted by the State Board of Vocational Nurse and Psychiatric Technician Examiners.

LOCAL MENTAL HEALTH PLAN (LMHP)

(See Mental Health Plan)

LOCKOUT (§1840.100)

A situation of circumstance under which Federal Financial Participation (FFP) is not available for a specific specialty mental health service.

MARRIAGE & FAMILY THERAPIST (MFT)

A person with a license to practice as a marriage & family therapist granted by the State Board of Behavioral Science Examiners. A licensed marriage & family therapist candidate who is registered or waived may assume certain roles and responsibilities of a licensed clinician, within scope of practice; e.g., provide therapy and develop and sign Client Care/Coordination Plans. Registered/waivered staff may document in the clinical record without co-signatures.

MEDICAID

The federal and state program that provides federal reimbursement to states for some of the costs of medical care for the poor and disabled. The State Department of Health Services is the “single State agency” charged with administering the program. Reimbursement for eligible mental health services are processed to that agency through the State Department of Mental Health.

MEDI-CAL

California’s Medicaid Program is called Medi-Cal.

MEDICAL NECESSITY

(See Chapter 1, *Service, Documentation, and Reimbursement Basics, Medi-Cal Medical Necessity*)

MEDICATION SUPPORT SERVICES (Meds or MSS)

[See **also** Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Medication Support Services and A Guide to Procedure Codes, Medication Support – SD/MC & FFS*]

MENTAL HEALTH PLAN (MHP) (§1810.226)

“Mental Health Plan” means an entity which enters into an agreement with the State DMH to arrange for and/or provide specialty mental health services to beneficiaries (clients) in a county...A MHP may be a county, counties acting jointly or another governmental or nongovernmental entity. For our purposes the MHP or LMHP is Los Angeles County Department of Mental Health.

MENTAL HEALTH REHABILITATION SPECIALIST (CCR, Title 9 §630)

A mental health rehabilitation specialist is an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years of post-associate arts clinical experience may be substituted for the required educational experience, in addition to the requirement of four years of experience in a mental health setting.

MENTAL HEALTH SERVICES (MHS)

[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Mental Health Services*]

MONTH OF INTAKE SCHEDULE-COORDINATED SERVICES

The Month of Intake Schedule refers to specific time frames for the completion of the Coordination Plan for each Client receiving Mental Health Services, Day Treatment Intensive, Day Rehabilitation, Adult Residential Services, or Medication Support Services. The Month of Intake Schedule also refers to specific time frames for the completion of Client Care Plans for Mental Health Services, Day Treatment Intensive, Day Rehabilitation or Adult Residential Services. The due date for a Client Care Plan and Coordination Plan are based on the month of his/her intake. The Month of Intake Schedule revolves on the first day of the month of intake. The Month of Intake is the month the Client first receives any of the following services: Medication Support, Case Management/Brokerage, Mental Health, Day Treatment Intensive, Day Rehabilitation, or Adult Residential Services.

OCCUPATIONAL THERAPISTS

An Occupational Therapist is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, and who is registered or who is eligible for registration by the American Occupational Therapy Association.

OTHER TIME

See “TYPES OF TIME” below.

OUTPATIENT HOSPITAL SERVICES

Outpatient Hospital Services can provide case management and/or rehabilitative service providers as long as they:

1. Are licensed or formally approved as a hospital by an officially designated authority for State Standards setting;
2. Meet the requirements for participation in Medicare; and
3. Provide basic mental health services.

PERSONAL CARE SERVICES

These are non-Medi-Cal or Medicare reimbursable services provided to the Client which they cannot perform for themselves or which the service provider cannot teach the Client to perform for themselves.

PHARMACIST

A person registered to practice by the State Board of Pharmacy. This license allows only the delivery of Medication Support Services under the Rehab Option. However, a pharmacist's education and/or experience may qualify him/her for one of the other Medi-Cal reimbursement staff categories.

PHYSICIAN

A person with a license to practice as a physician granted by the State Medical Board of California.

PLAN DEVELOPMENT (§1810.232)

“Plan Development” means a service activity that consists of the development of client plans, approval of client plans, and/or monitoring of a client's progress.

PROVIDER (§1810.235)

A person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program as described in CCR, Title 9, Chapter 11 and in Division 3, Subdivision 1 of Title 22. Provider includes licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, and hospitals. The MHP is a provider when direct services are provided to clients by employees of the MHP.

PSYCHIATRIC HEALTH FACILITY (PHF)

(See Chapter 5, *Regulations and Requirements for Services Based on Calendar Days, Psychiatric Health Facility, Definition*)

PSYCHIATRIC HEALTH FACILITY SERVICES

(See Chapter 5, *Regulations and Requirements for Services Based on Calendar Days, Psychiatric Health Facility, Services*)

PSYCHIATRIC NURSING FACILITY SERVICES (§1810.238)

Skilled nursing facility services as defined in Title 22, Section 51123, that include special treatment program services for mentally disordered persons as defined in Chapter 3, Division 5, Title 22, provided by an entity that is licensed as a skilled nursing facility by the State Department of Health Services and is certified by the department to provide special treatment program services.

PSYCHIATRIST

A Psychiatrist shall have a license to practice as a physician and surgeon granted by the Medical Board of California and show evidence of having completed the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program training accredited by the Accreditation Council for Graduate Medical Education, the American Medical Association or the American Osteopathic Association.

PSYCHOLOGICAL TESTING (PsyT)

[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Mental Health Services, Psychological Testing*]

PSYCHOLOGIST

A psychologist shall have obtained a license to practice as a clinical psychologist granted by the State Board of Psychology, Medical Board of California. A psychologist with a waiver may assume certain roles and responsibilities of a licensed clinician, within scope of practice; e.g., provide therapy and develop and sign Client Care/Coordination Plans. Registered/Waivered staff may document in the clinical record without co-signatures.

RECREATION

Non Medi-Cal reimbursable activities which have as their sole purpose relaxation, leisure, or entertainment.

REGISTERED NURSE

A nurse shall be licensed to practice as a registered nurse by the California Board of Registered Nursing.

REHABILITATION

[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Rehabilitation*]

RENDERING PROVIDER

This is the staff who provided or was involved in the provision of service and wrote the progress note. The claim for the service must be submitted under this person's name.

SERVICE PLAN – See CLIENT CARE/COORDINATION PLAN**SIGNIFICANT SUPPORT PERSON (§1810.246.1)**

(Also see COLLATERAL)

“Significant support persons” means persons, in the opinion of the client or the person providing the service who have or could have a significant role in the successful outcome of treatment, including, but not limited to the parents or legal guardian of a client who is a minor; the legal representative of a client who is not a minor; a person living in the same household as the client; the client's spouse, and relatives of the client.

SINGLE FIXED POINT OF RESPONSIBILITY (SFPR)

Alternate language for “Coordinator” in Los Angeles County.

SOCIALIZATION

(See Chapter 4, *Regulations and Requirements for Services Based on Blocks of Time (Mode 10) County General Fund Reimbursable Services, 4-hour Blocks of Time, Socialization Services*)

SPECIALTY MENTAL HEALTH SERVICES (§1810.247)

“Specialty Mental Health Services” means:

- a. Rehabilitative Services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, and psychiatric health facility services;
- b. Psychiatric Inpatient Hospital Services;
- c. Targeted Case Management;
- d. Psychiatric Services;
- e. Psychologist Services
- f. EPSDT Supplemental Specialty Mental Health Services; and
- g. Psychiatric Nursing Facility Services.

STANDARD REASON FOR DISALLOWANCES

State Department of Mental Health documents which list all of the standard reasons to take disallowances for non-compliance under the Medi-Cal program, e.g., attachments to SDMH Information Notices regarding audits, such as “Reasons for Recoupment.”

STUDENT

A person, paid or unpaid, undergraduate or graduate, delivering services in the LA County mental health system of care under a formal agreement with the County Department of Mental Health covering the student experience. The documentation of all client services provided by a student must be co-signed by the student’s supervisor.

TARGETED CASE MANAGEMENT (TCM)

[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Targeted Case Management*]

THERAPY (CCR, Title 9, Division 1, §543)

A goal directed clinical intervention with a client which focuses on the mental health needs of the client.

(See **also** Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Mental Health Services, Therapy* for additional information and for the State regulation definition.)

TOTAL TIME

See “TYPES OF TIME” below.

TWO YEARS EXPERIENCE PROVIDING SERVICES IN THE MENTAL HEALTH FIELD (PAID or UNPAID)

The local mental health director shall be responsible for describing or approving specific criteria used to determine the adequacy of a staff person’s work experiences providing services in the mental health field, paid or unpaid, and the applicability of those skills and experiences in the provision of services to Clients.

TYPES OF TIME

- **Face-to-Face Time:** This time is defined very literally, that is, the time a client is visually in the presence of and interacting in some way with staff. In many situations, “Face-to-face Time” will be zero with all the service time recorded and reported as “Other Time”.
- **Other Time:** This includes non-face-to-face contacts (such as phone calls) with a client or his/her collaterals, time performing reimbursable non-contact services (such as writing a discharge summary), and documentation and travel time.
- **Total Time:** This is the time on which the Department is reimbursed for outpatient services. It is the total of “Face-to-face Time” and “Other Time”. For the Rendering Provider of non-group services, the computer calculates this time by totaling the entered “Face-to-face Time” and “Other Time”. The Rendering Provider of group services records in the record and

reports only “Total Time”. All other staff participants of a service, whether group or non-group, record and report “Total Time” only.

URGENT CONDITION (§1810.253)

“Urgent Condition” means a situation experienced by a client that, without timely intervention, is certain to result in an immediate emergency psychiatric condition.

VOCATIONAL SERVICES

(See Chapter 4, *Regulations and Requirements for Services Based on Blocks of Time (Mode 10), County General Fund Reimbursable Services, 4-hour Blocks of Time, Vocational Services*)

WAIVERED/REGISTERED PROFESSIONAL (§1810.254)

An individual who has a waiver of psychologist licensure issued by the State Department of Mental Health or has registered with the applicable state licensing authority to obtain supervised clinical hours for Marriage, Family, and Child Counselor or Clinical Social Worker licensure..

WINDOW PERIOD

The Window Period refers to the specific timelines for the review and update of the Client Care/Coordination Plan. One month window periods occur the month prior to the Coordination Cycle Date and the month prior to its six-month anniversary. A Plan signed any time during the window period shall be effective for the subsequent period.

APPENDIX

Chapter 1

Website addresses

Examples of Medi-Cal Reimbursable and Non-Reimbursable Vocational, Educational, Recreational and Socialization Activities

LAC-DMH memo, December 1, 2003, "Documentation of Mental Health Services"

Progress Note Samples

Medi-Cal Included Diagnoses

Website Addresses

- **State DMH Letters and Notices:** www.dmh.ca.gov/DMHDocs/
Click on [DMH Letters](#) or [DMH Notices](#). The Letters and Notices are referenced by a number. The first two numbers are the year of issue; the number after the dash is the numerical order in which the document was issued in that year.
- **California Code of Regulations:** At www.dmh.ca.gov/DMHDocs/, click on [Laws & Regulations](#) in the contents column on the left side of the web page. At the Office of Regulations home page, click on [Laws and Regulations Publication](#) in the left hand content column. Scroll to the bottom of the page and click on [California Code of Regulations](#) on the right. In the box “Query Templates,” click on “Go to a Specific Section” and follow the directions. The section you are seeking will be displayed. If you follow a short-cut by going directly to the Codes, you may not always locate the code section(s) you are seeking.
- **Code of Federal Regulations (CFR):** You may search for specific CFR items at the website, <http://www.gpoaccess.gov/cfr/>.
- **LAC-DMH Procedure Codes Guide:**
 - From the Internet:
The main LAC-DMH web page is <http://dmh.lacounty.gov>. Click “Provider Tools” (on the left side of the screen), then “[Integrated System](#)”. For the most recent “Procedure Codes Guide”, click on “[Procedure Codes Manual](#)” found on the front page.
 - From the Intranet:
At the LAC-DMH Intranet page, click on the top tab titled “Hipaa”. For the most recent “Procedure Codes Guide”, click on “[Procedure Codes Manual](#)” found on the front page.
- **LAC-DMH SC/MC Organizational Provider’s Manual**
 - From the Internet:
The main LAC-DMH web page is <http://dmh.lacounty.gov>. Click “Provider Tools” (on the left side of the screen), then “Agency Administration”. Organizational Provider’s Manual is listed in the center of the screen under “Provider Manuals”

Examples of Medi-Cal Reimbursable and Non-Reimbursable
Vocational, Educational, Recreational and Socialization Activities

Vocational Examples:

- Assisting the client to consider how the boss' criticism affects him/her and strategies for handling the situation **is** reimbursable no matter where the service is delivered.
- Visiting a client's job site to teach him/her a job skill **is not** reimbursable.
- Responding to the employer's call for assistance when the client is in tears at work because they are having trouble learning a new cash register **is** reimbursable if the focus of the intervention is assisting the client to decrease their anxiety enough to concentrate on the task of learning the new skill.
- Providing hands-on technical assistance to the client regarding the new cash register **is not** reimbursable.

Educational Examples:

- Sitting with a client in a community college class the first three times the client attends and debriefing the experience afterward **is** reimbursable.
- Assisting the client with their homework **is not** reimbursable.
- Assisting the client with the arithmetic necessary to help him/her manage their household budget **is** reimbursable.
- Teaching a class in remedial English **is not** reimbursable.
- Assisting a client to find tutorial help in English **is** reimbursable.
- Teaching a typing class on site at an adult residential treatment program in preparation for entry into a formal job training program **is not** reimbursable.
- Helping the individual with typing skills while he/she is working on a newsletter **is** reimbursable.

Recreational Examples:

- Helping clients improve their communication skills during a recreational activity **is** reimbursable.
- Playing basketball with clients or teaching them how to lift weights so that they do not injure themselves **is not** reimbursable.

Socialization Examples:

- Playing cards or any other games with a client or group of clients **is not** reimbursable.
- Helping the client learn better social skills so he/she will be better able to interact with people **is** reimbursable.

PROGRESS NOTES

Date, Service, Procedure Code, *Hrs./Minutes	<p>◆ Services submitted for SD/MC reimbursement have been determined to be appropriate and medically necessary.</p> <p>◆ Refer to Medication Log for specific medication information when "medications prescribed", "medication renewed", or "medications administered" is noted on this form.</p>
Documentation of Out-of-Sequence/Late Entries	
1/10/05	Upon request of client, I made a telephone call to Bill's Board and Care Home to make an
TCM – "PC"	appointment for the client to meet with Bill on Thursday, 1/12/05, at 10:00 a.m. I gave the client a
0/:20	sheet of paper with the name of the B&C home, address, and Bill's name, along with the appointment date and time.
	<i>Signature/Discipline</i>
① 1/5/05	④ Note written on 1/10/05. ⑤ Talked with client about his anxiety regarding living in a board and
② I – "PC" ③	care home. ⑥ Client remains ambivalent and, as yet, has not taken any actions to contact any
:20/:15	residential facility.
	<i>Signature/Discipline</i>

1/16/05	Client kept his appointment at the board and care home. We talked about his fears of living away from
I – "PC"	his parents. The client liked the home, and although he is anxious about the move, he is feeling he
⑦ 1:15/:10	would like to live there. Supported client for keeping his appointment and for being willing to make
	this difficult decision. Encouraged client to talk with parents about this before our next appointment on
	1/22/05, at 2:00 p.m.
	<i>Signature/Discipline</i>
<u>Explanations</u>	
	① The service date is placed in the left column of the note.
	② Include the type of service (I=individual, Gr=Group, Col=Collateral, PsyT=Psych Testing, CC=Case Conference; TCM=Targeted Case Management; Meds or MSS=Med Support)
	③ "PC" is used in this example instead of an actual Procedure Code . In an actual note, use the appropriate procedure code.
	④ If a note is written out-of-sequence, it is considered a late entry. The date on which the note was written should appear at the beginning of the note. ⑤ Staff must state the intervention he/she attempted or accomplished toward the client's goals/milestones.
	⑥ This note also includes the client's response/progress toward his goals/milestones.
	⑦ Note the time should be written in hr:minutes. In this example the staff person spent 1 hour 15 minutes face-to-face time and 10 minutes other time which includes travel and documentation. The computer calculates the total time of 85 minutes that will be claimed.

***All travel and documentation time must be associated with the activity.**

<p>This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.</p>	<p>Name: Doe, John MIS#: 0000000</p> <p>Agency: Headquarters Provider #: XXXX</p> <p style="text-align: center;">Los Angeles County – Department of Mental Health</p>
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PROGRESS NOTES

PROGRESS NOTES

Date, Service, Procedure Code, *Hrs./Minutes	<p>◆ Services submitted for SD/MC reimbursement have been determined to be appropriate and medically necessary. ◆ Refer to Medication Log for specific medication information when "medications prescribed", "medication renewed", or "medications administered" is noted on this form.</p>
Documentation of Non-Group Contacts Involving More than One Staff	
① 2/1/2005	Client's child's case manager, ⑤ Susie Smith, MSW, participated in session. ⑥ Ms. Smith shared
② I – "PC" ③	her observed behavior of the child in the classroom; how the behavior was handled and the child's
④ :55/:15	response. ⑦ I talked with this client about her handling of similar behaviors and the problems/feelings
:55 (SS)	she has that keep her from modifying her interactions with her child. (Additional information re interventions and client response, as appropriate.) ⑧ one Signature/Discipline
<u>Explanations</u>	
① The date in the left column is the service date.	
② The type of service (I=individual, Gr=Group, Col=Collateral, PsyT=Psych Testing, CC=Case Conference; TCM=Targeted Case Management; Meds or MSS=Med Support) must be indicated.	
③ "PC" was used in this sample instead of an actual procedure code. In an actual note, the appropriate procedure code, under which services were claimed, would be used.	
④ When more than one staff are involved in the contact, the time spent, including travel and documentation, for each must be noted in the left column. The rendering provider must break out the face-to-face and "other" time. The second staff person only notes total time. Place the initials of the second staff person next to his/her total time. In this example the rendering staff person spent 55 minutes face-to-face time and 15 minutes other time. The second staff person spent a total time of 55 minutes. The initials of the second staff person are noted next to her claimed time.	
⑤ The name of the second staff person must be included in the note.	
⑥ With the exception of a co-leader in a group, a statement of justification/contribution is required for the second staff person involved in the contact.	
⑦ The primary staff must state the interventions he/she attempted or accomplished toward the client's goals/milestones.	
⑧ Even though two staff participated in this contact, only the rendering provider signs the note.	

***All travel and documentation time must be associated with the activity.**

<p>This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.</p>	<p>Name: Doe, John MIS#: 0000000</p> <p>Agency: Headquarters Provider #: XXXX</p> <p style="text-align: center;">Los Angeles County – Department of Mental Health</p>
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MEDI-CAL INCLUDED OUTPATIENT AND DAY SERVICE ICD-10-CM DIAGNOSIS

F200	Paranoid schizophrenia	F3176	Bipolar disorder, in full remis, most recent episode depress
F201	Disorganized schizophrenia	F3177	Bipolar disord, in partial remis, most recent episode mixed
F202	Catatonic schizophrenia	F3178	Bipolar disorder, in full remis, most recent episode mixed
F203	Undifferentiated schizophrenia	F3181	Bipolar II disorder
F205	Residual schizophrenia	F3189	Other bipolar disorder
F2081	Schizophreniform disorder	F319	Bipolar disorder, unspecified
F209	Schizophrenia, unspecified	F320	Major depressive disorder, single episode, mild
F21	Schizotypal disorder	F321	Major depressive disorder, single episode, moderate
F22	Delusional disorders	F322	Major depressv disord, single epsd, sev w/o psych features
F23	Brief psychotic disorder	F323	Major depressv disord, single epsd, severe w psych features
F24	Shared psychotic disorder	F324	Major depressv disorder, single episode, in partial remis
F250	Schizoaffective disorder, bipolar type	F325	Major depressive disorder, single episode, in full remission
F251	Schizoaffective disorder, depressive type	F328	Other depressive episodes
F258	Other schizoaffective disorders	F329	Major depressive disorder, single episode, unspecified
F259	Schizoaffective disorder, unspecified	F330	Major depressive disorder, recurrent, mild
F28	Other psychotic disorder not due to a substance or known physiological condition	F331	Major depressive disorder, recurrent, moderate
F29	Unspecified psychosis not due to a substance or known physiological condition	F332	Major depressv disorder, recurrent severe w/o psych features
F3010	Manic episode without psychotic symptoms, unspecified	F333	Major depressv disorder, recurrent, severe w psych symptoms
F3011	Manic episode without psychotic symptoms, mild	F33.40	Major depressive disorder, recurrent, in remission, unsp
F3012	Manic episode without psychotic symptoms, moderate	F3341	Major depressive disorder, recurrent, in partial remission
F3013	Manic episode, severe, without psychotic symptoms	F3342	Major depressive disorder, recurrent, in full remission
F302	Manic episode, severe with psychotic symptoms	F338	Other recurrent depressive disorders
F303	Manic episode in partial remission	F339	Major depressive disorder, recurrent, unspecified
F304	Manic episode in full remission	F340	Cyclothymic disorder
F308	Other manic episodes	F341	Dysthymic disorder
F30.9	Manic episode, unspecified	F348	Other persistent mood [affective] disorders
F3110	Bipolar disord, crnt episode manic w/o psych features, unsp	F349	Persistent mood [affective] disorder, unspecified
F3111	Bipolar disord, crnt episode manic w/o psych features, mild	F39	Unspecified mood [affective] disorder
F3112	Bipolar disord, crnt episode manic w/o psych features, mod	F4000	Agoraphobia, unspecified
F3113	Bipolar disord, crnt epsd manic w/o psych features, severe	F4001	Agoraphobia with panic disorder
F312	Bipolar disord, crnt episode manic severe w psych features	F4002	Agoraphobia without panic disorder
F3130	Bipolar disord, crnt epsd depress, mild or mod severt, unsp	F4010	Social phobia, unspecified
F3131	Bipolar disorder, current episode depressed, mild	F4011	Social phobia, generalized
F3132	Bipolar disorder, current episode depressed, moderate	F40210	Arachnophobia
F314	Bipolar disord, crnt epsd depress, sev, w/o psych features	F40218	Other animal type phobia
F315	Bipolar disord, crnt epsd depress, severe, w psych features	F40220	Fear of thunderstorms
F3160	Bipolar disorder, current episode mixed, unspecified	F40228	Other natural environment type phobia
F3161	Bipolar disorder, current episode mixed, mild	F40230	Fear of blood
F3162	Bipolar disorder, current episode mixed, moderate	F40231	Fear of injections and transfusions
F3163	Bipolar disord, crnt epsd mixed, severe, w/o psych features	F40232	Fear of other medical care
F3164	Bipolar disord, crnt episode mixed, severe, w psych features	F40233	Fear of injury
F3170	Bipolar disord, currently in remis, most recent episode unsp	F40240	Claustrophobia
F3171	Bipolar disorder, in partial remis, most recent epsd hypomanic	F40241	Acrophobia
F3172	Bipolar disorder, in full remis, most recent episode hypomanic	F40242	Fear of bridges
F3173	Bipolar disorder, in partial remis, most recent episode manic	F40243	Fear of flying
F3174	Bipolar disorder, in full remis, most recent episode manic	F40248	Other situational type phobia
F3175	Bipolar disorder, in partial remis, most recent epsd depress	F40290	Androphobia

MEDI-CAL INCLUDED OUTPATIENT AND DAY SERVICE ICD-10-CM DIAGNOSIS (continued)

F40291	Gynephobia	F6381	Intermittent explosive disorder
F40298	Other specified phobia	F639	Impulse disorder, unspecified
F408	Other phobic anxiety disorders	F641	Gender identify disorder in adolescence and adulthood
F410	Panic disorder without agoraphobia	F642	Gender identify disorder in childhood
F411	Generalized anxiety disorder	F649	Gender identify disorder, unspecified
F413	Other mixed anxiety disorders	F650	Fetishism
F418	Other specified anxiety disorders	F651	Transvestic fetishism
F419	Anxiety disorder, unspecified	F652	Exhibitionism
F42	Obsessive-compulsive disorder	F653	Voyeurism
F430	Acute stress reaction	F654	Pedophilia
F4310	Post-traumatic stress disorder, unspecified	F6550	Sadomasochism, unspecified
F4311	Post-traumatic stress disorder, acute	F6551	Sexual masochism
F4312	Post-traumatic stress disorder, chronic	F6552	Sexual sadism
F4320	Adjustment disorder, unspecified	F6581	Frotteurism
F4321	Adjustment disorder with depressed mood	F659	Paraphilia, unspecified
F4322	Adjustment disorder with anxiety	F6810	Factitious disorder, unspecified
F4323	Adjustment disorder with mixed anxiety and depressed mood	F6811	Factitious disorder with predominantly psychological signs and symptoms
F4324	Adjustment disorder with disturbance of conduct	F6812	Factitious disorder with predominantly physical signs and symptoms
F4325	Adjustment disorder w mixed disturb of emotions and conduct	F6813	Factitious disorder with combined psychological and physical signs and symptoms
F440	Dissociative amnesia	F842	Rett's syndrome
F441	Dissociative fugue	F843	Other childhood disintegrative disorder
F444	Conversion disorder with motor symptom or deficit	F845	Asperger's syndrome
F445	Conversion disorder with seizures or convulsions	F848	Other pervasive developmental disorders
F446	Conversion disorder with sensory symptom or deficit	F849	Pervasive developmental disorder, unspecified
F447	Conversion disorder with mixed symptom presentation	F900	Attention-deficit hyperactivity disorder, predominantly inattentive type
F4481	Dissociative identity disorder	F901	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F449	Dissociative and conversion disorder, unspecified	F902	Attention-deficit hyperactivity disorder, combined type
F450	Somatization disorder	F90.9	Attention-deficit/hyperactivity disorder, unspecified type
F451	Undifferentiated somatoform disorder	F911	Conduct disorder, childhood-onset type
F4522	Body dysmorphic disorder	F912	Conduct disorder, adolescent-onset type
F4541	Pain disorder exclusively related to psychological factors	F913	Oppositional defiant disorder
F4542	Pain disorder with related psychological factors	F919	Conduct disorder, unspecified
F458	Other somatoform disorders	F930	Separation anxiety disorder of childhood
F481	Depersonalization-derealization syndrome	F938	Other childhood emotional disorders
F5000	Anorexia nervosa, unspecified	F939	Childhood emotional disorder, unspecified
F5001	Anorexia nervosa, restricting type	F940	Selective mutism
F5002	Anorexia nervosa, binge eating/purging type	F941	Reactive attachment disorder of childhood
F502	Bulimia nervosa	F980	Enuresis not due to a substance or known physiol condition
F509	Eating disorder, unspecified	F981	Encopresis not due to a substance or known physiol condition
F600	Paranoid personality disorder	F9821	Rumination disorder of infancy
F601	Schizoid personality disorder	F9829	Other feeding disorders of infancy and early childhood
F603	Borderline personality disorder	F983	Pica of infancy and childhood
F604	Histrionic personality disorder	F98.4	Stereotyped movement disorders
F605	Obsessive-compulsive personality disorder	G210	Malignant neuroleptic syndrome
F606	Avoidant Personality Disorder	G2111	Neuroleptic induced parkinsonism
F607	Dependent personality disorder	G244	Idiopathic orofacial dystonia
F6081	Narcissistic personality disorder	G251	Drug-induced tremor
F609	Personality disorder, unspecified	G2570	Drug-induced movement disorder, unspecified
F630	Pathological gambling	G2571	Medication-induced acute akathisia
F631	Pyromania	G25.9	Extrapyramidal and movement disorder, unspecified
F632	Kleptomania	R150	Incomplete defecation
F633	Trichotillomania	R159	Full incontinence of feces

Chapter 2

“Documentation for Services Based on Minutes of Time”

Quality Improvement Communiqué No. 4, December 13, 1993 (updated March 18, 2002)

Documentations for Services Based on Minutes of Time

Two Staff Provide Different Services in a Single Contact

Example 1: A physician and a nurse participate in a single contact, but provide different services and document their services separately – the physician prescribes a medication and the nurse administers the medication; two Medication Support Services claims should be documented and submitted.

Example 2: a physician and a case manager participate in a single Medication Support Service – the physician prescribes a medication and the case manager facilitates (language or cultural) their interaction and the client's access to MSS; the physician would claim a MSS and the case manager a TCM.

Two Staff Provide Group Services

Example 1: A service is provided by two staff to a group of five Medi-Cal eligible clients and two who are not. The reimbursable service (including direct service, travel time, plan development, and documentation) lasts 1 hour and 40 minutes for the Rendering Provider and one hour for the second staff person. The note must document the entire service, including the intervention contributions of each staff present. The note begins with language similar to "Co-led service with Suzie Smith, MSW intern." (The name of the staff his/her title are required elements.) Each staff person's total time, including the Rendering Provider, is the only time that needs to be documented. The computer will total the time of both staff (two hours and 20 minutes or 140 minutes) and divide that time by 7. Twenty minutes will be claimed to Medi-Cal for 5 clients and 20 minutes each for the two non-Medi-Cal clients to their appropriate payer source.

Example 2: A group of four clients and seven collaterals meet with two staff. Two clients are not present at this group session, but are represented by collaterals making six the number of clients present or represented. The group meets with the Rendering Provider for 1 hour and 30 minutes; the Rendering Provider documents in all six records for an additional 30 minutes. The second staff is present for only one hour of the group. All clients are listed on the Group Service Log, including the two not present. The Rendering Provider claims 2 hours of time and the second staff one hour. The computer total these times to 180 minutes and claims 30 minutes (180 divided by 6) to each client.



Quality Improvement Communique

December 13, 1993

No. 4

*Standards and Records, Quality and Outcome Bureau
Office of the Medical Director, Department of Mental Health*

This issue of the Quality Improvement Communique is devoted to the Los Angeles County application of the State's Rehab Option Bulletin dated August 20, 1993, Vol. 1, No. 3. In order to minimize confusion and ensure Los Angeles County applications of State DMH information are joined together, the County has, with the permission of the State, intertwined its comments into the State's Bulletin. Los Angeles County comments are in italics; text not applicable to the County is struck out.

STATE
DEPT.



REHAB OPTION BULLETIN

August 20, 1993

Vol. 1, No. 3

The final authority on all matters related to the Rehabilitation Option is the Short-Doyle/Medi-Cal Manual for the Rehabilitation Option and Targeted Case Management issued with DMH Letter 93-09.

This rehab option bulletin provides responses and clarification to questions raised during statewide training on coordinated services and the Rehab Option in April, May, June 1993. Questions and concerns raised since implementation of the Rehab Option and Coordinated Services began July 1, 1993 are also addressed.

3.1 When providing Crisis Intervention, can you bill for services on the phone?

Yes, if LA County DMH has approved your use of Crisis Intervention Service Function Codes. Crisis Intervention Services may be either face to face or by telephone with the Individual or significant support person. The situation must meet the definition of Crisis Intervention and documentation must meet all the standards in the Manual including indication that the acuity of the individual or situation justifies Crisis Intervention. (SD/MC Rehab Option Manual, Pages 2-29 and 4-36).

3.2 If the physician goes out into the community on a crisis call, can you bill for a crisis?

Yes. Crisis Intervention could be billed assuming the ~~notes~~ *documentation meets all the requirements in the State Manual including that the acuity of the individual or situation justifies Crisis Intervention. (SD/MC Rehab Option Manual, Page 2-29 and 4-36).* Please note that if *any portion of the service the physician provides is Medication Support, the time spent providing medication support should be claimed to that service function would be billed.* For example, a physician goes with another staff person on a crisis call. Three hours lapse from the time they leave their work location to the time they both return from the crisis call. During the call, the physician spent 30 minutes on medication related issues (discussing, prescribing, &/or administering meds). In one claim, supported by a medication note, the physician would claim 30 minutes of Medication Support Services (Meds). In a second claim, supported by the Crisis Intervention note indicating the time of both staff, the non-physician would report 3 hrs of Crisis Intervention and the physician would report 2 hr, 30 min. (In the left column of the Progress Notes form, the time of these two staff providing Crisis Intervention would be recorded as 3:00/2:30.) The physician could claim all of his/her time as Crisis Intervention, but Meds does reimburse at a higher rate.

3.3 A crisis worker talks to a board and care operator regarding Medi-Cal eligible client at the home. The board and care operator tells the crisis worker that the client is having a crisis. The crisis worker goes there and things are calm. Can you bill Crisis Intervention?

Yes, Crisis Intervention may be billed for staff time if *documentation of the caller's information indicates a crisis existed at the time of the call.* ~~your best information was that it was a crisis and there is documentation to that effect.~~

B R E A K

3.17 The following question clarifies question 2.11 in Rehab Option Bulletin No. 2.

Vocational Services (Mode 10, Service Function 30-39), and Socialization (Mode 10, Service Function 40-49) are reportable to CDS and CR/DC, and are counted in 4 hour increments as follows:

Less than or equal to 4 hours = 1 block of services
Greater than 4 and up to 8 hours = 2 blocks of services

Chapter 3

California Code of Regulations (CCR), Title 9, Chapter 11, §1850.210

TITLE 9. Rehabilitative And Developmental Services
Division 1. Department of Mental Health
Chapter 11. Medi-Cal Specialty Mental Health Services
Subchapter 5. Problem Resolution Processes
§1850.210. Fair Hearing and Notice of Action.

§1850.210. Fair Hearing and Notice of Action.

(a) The MHP shall provide a beneficiary of the MHP with a Notice of Action when the MHP acts to deny an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. Notice in response to an initial request from a provider shall be provided in accordance with this subsection. Notice in response to a request for continuation of a specialty mental health service shall be provided in accordance with Title 22, Section 51014.1. The Notice of Action under this subsection shall not be required in the following situations:

- (1) The denial is a denial of a request for MHP payment authorization for a specialty mental health service that has already been provided to the beneficiary.
- (2) The denial is a non-binding verbal description to a provider of the specialty mental health services which may be approved by the MHP.

(b) The MHP of the beneficiary shall provide the beneficiary with a Notice of Action when the MHP defers action on an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. The Notice of Action shall be delayed for 30 calendar days to allow the provider of the specialty mental health service time to submit the additional information requested by the MHP and to allow time for the MHP to make a decision. If, after 30 calendar days from the MHP's receipt of the MHP payment authorization request, the provider has not complied with the MHP's request for additional information, the MHP shall provide the beneficiary a notice of action to deny the service pursuant to subdivision (a). If, within that 30 day period, the provider does comply, the MHP shall take appropriate action on the MHP payment authorization request as supplemented by the additional information, including providing a Notice of Action to the beneficiary if the service is denied or modified or if the MHP defers action on the MHP payment authorization request for an additional period of time. The Notice of Action under this subsection shall not be required when the MHP defers action on an MHP payment authorization request for a specialty mental health service that has already been provided to the beneficiary.

(c) The MHP shall provide a beneficiary of the MHP with a Notice of Action when the MHP modifies an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. Notice in response to an initial request from a provider shall be provided in accordance with Title 22, Section 51014.1. The Notice of Action pursuant to this subsection shall not be required when the MHP modifies the duration of any approved specialty mental health services as long as the MHP provides an opportunity for the provider to request MHP payment authorization of additional specialty mental health services before the end of the approved duration of services. The Notice of Action under this subsection shall not be required when the MHP modifies

an MHP payment authorization request for a specialty mental health service that has already been provided to the beneficiary.

(d) The written Notice of Action issued pursuant to subsections (a), (b), or (c) shall be deposited with the United States postal service in time for pick-up no later than the third working day after the action and shall specify:

- (1) The action taken by the MHP.
- (2) The reason for the action taken.
- (3) A citation of the specific regulations or MHP payment authorization procedures supporting the action.
- (4) The beneficiary's right to a fair hearing, including:
 - (A) The method by which a hearing may be obtained.
 - (B) That the beneficiary may be either:
 1. Self-represented.
 2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.
 - (C) An explanation of the circumstances under which a specialty mental health service will be continued if a fair hearing is requested.
 - (D) The time limits for requesting fair hearing.

(e) The fair hearings under this section shall be administered by the State Department of Health Services.

(f) For the purpose of this section, each reference to Medi-Cal managed care plan in Title 22, Section 50114.1, shall mean the MHP.

(g) For the purposes of this section, "mental service" as cited in Title 22, Section 51014.1, shall mean those specialty mental health services that are subject to prior authorization by an MHP pursuant to subchapters 2 and 3.

(h) The provisions of this section do not apply to the decisions of providers including the MHP serving beneficiaries when prior authorization of the service by the MHP's authorization procedures is not a condition of payment to the provider for the specialty mental health service.

(i) When a Notice of Action would not be required under subsections (a), (b), or (c), the MHP of the beneficiary shall provide a beneficiary with Notice of Action under this subsection when the MHP or its providers determine that the medical necessity criteria in Section 1830.205(b)(1), (b)(2) or (b)(3)(C) or Section 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. The Notice of Action under this subsection, shall, at the election of the MHP, be hand delivered to the beneficiary on the date of the action or mailed to the beneficiary in accordance with subsection (d) and shall specify:

- (1) The reason the mental necessity criteria was not met.
- (2) The beneficiary's options for obtaining care outside the MHP, if applicable.
- (3) The beneficiary's right to request a second opinion on the determination.

- (4) The beneficiary's right to file a complaint or grievance with the MHP.
- (5) The beneficiary's right to a fair hearing, including:
 - (A) The method by which a hearing may be obtained.
 - (B) That the beneficiary may be either:
 - 1. Self-represented.
 - 2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.
 - (C) The time limits for requesting fair hearing.

NOTE

Authority cited: Section 14684, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

HISTORY

- 1. New section filed 10-31-97 as an emergency; operative 11-1-97 (Register 97, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-2-98 or emergency language will be repealed by operation of law on the following day.
- 2. New section refiled 3-2-98 as an emergency; operative 3-2-98 (Register 98, No. 10). A Certificate of Compliance must be transmitted to OAL by 6-30-98 or emergency language will be repealed by operation of law on the following day.
- 3. New section refiled 6-17-98 as an emergency; operative 6-30-98 (Register 98, No. 25). Pursuant to Chapter 324 (Statutes of 1998) Item 4440-103-0001(4), a Certificate of Compliance must be transmitted to OAL by 7-1-99 or emergency language will be repealed by operation of law on the following day.
- 4. Editorial correction of History 3 (Register 98, No. 39).
- 5. Editorial correction extending Certificate of Compliance date to 7-1-2001 pursuant to Chapter 50 (Statutes of 1999) Item 4440-103-0001(4) (Register 99, No. 33).
- 6. Editorial correction of History 5 (Register 2000, No. 42).

Chapter 4

“Staffing Requirements for Day Treatment Programs”

Quality Improvement Communiqué No. 4, December 13, 1993 (updated March 18, 2002) See Appendix Chapter 2.

STAFFING REQUIREMENTS FOR DAY TREATMENT PROGRAMS

Day Treatment Intensive (DTI)

At a minimum there must be an average ratio of at least one person from the following list providing DTI services to **8** clients in attendance during the period the program is open.

DTI programs serving more than **12** clients shall include at least one person from each of the two following staff categories:

- Physicians
- Psychologists or related waived/registered professionals
- Licensed Clinical Social Workers or related waived/registered professionals
- Marriage, Family and Child Counselors (MFT's) or related waived/registered professionals
- Registered Nurses
- Licensed Vocational Nurses
- Psychiatric Technicians
- Occupational Therapists
- Mental Health Rehabilitation Specialists as defined in §630.

Day Rehabilitation (DR)

At a minimum there must be an average ratio of at least one person from the following list providing DR services to **10** clients in attendance during the period the program is open:

- Physicians
- Psychologists or related waived/registered professionals
- Licensed Clinical Social Workers or related waived/registered professionals
- Marriage, Family and Child Counselors (MFT's) or related waived/registered professionals
- Registered Nurses
- Licensed Vocational Nurses
- Psychiatric Technicians
- Occupational Therapists
- Mental Health Rehabilitation Specialists as defined in §630.

Persons providing services in DR programs serving more than **12** clients shall include at least two of the following:

- Physicians
- Psychologists or related waived/registered professionals
- Licensed Clinical Social Workers or related waived/registered professionals
- Marriage, Family and Child Counselors (MFT's) or related waived/registered professionals
- Registered Nurses
- Licensed Vocational Nurses
- Psychiatric Technicians
- Mental Health Rehabilitation Specialists as defined in §630.

Chapter 5

California Code of Regulations (CCR), Title 9, §531

CCR, Title 9, §532

CCR, Title 9, §1820.205

CCR, Title 22, §77073

CCR, Title 22, §77061

CCR, Title 22, §77004, §77011.2, §77012, §77012.1, §77012.2, §77017, §77023, §77059-77069 (§77061 in this series is found listed above), §77079.1, and §77079.12

TITLE 9. Rehabilitative And Developmental Services

Division 1. Department of Mental Health

Chapter 3. Community Mental Health Services Under the Short-Doyle Act

Article 3.5. Standards for the Certification of Social Rehabilitation Programs

§531. Program Standards and Requirements.

§531. Program Standards and Requirements.

(a) To be certified as a Short-Term Crisis Residential Treatment Program, a program shall provide:

(1) Services as specified in either subsection (e) or (f) of section 541 as an alternate to hospitalization for individuals experiencing an acute psychiatric episode or crisis. The planned length of stay in the program shall be in accordance with the client's assessed needs, but not to exceed thirty (30) days, unless circumstances require a longer length of stay to ensure successful completion of the treatment plan and appropriate referral. The reasons for a length of stay beyond thirty (30) days shall be documented in the client's case record. Under no circumstances may the length of stay exceed three (3) months.

(2) Scheduling of staff which provides for at least two (2) staff members to be on duty 24 hours a day, seven (7) days per week. If program design results in some clients not being in the facility during specific hours of the day, scheduling adjustments may be made so that coverage is consistent with and related to the number and needs of clients in the facility. During the night time hours, when clients are sleeping, only one of the two on duty staff members need be awake, providing the program does not accept admissions at that time. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff for each 1.6 clients served.

(b) To be certified as a Transitional Residential Treatment Program, a program shall provide:

(1) Services as specified in either subsection (h) or (i) of section 541 which shall provide a therapeutic environment in which clients are supported in their efforts to acquire and apply interpersonal and independent living skills. The program shall also assist the client in developing a personal community support system to substitute for the program's supportive environment and to minimize the risk of hospitalization and enhance the capability for independent living upon discharge from the program. The planned length of stay in the program shall be in accordance with the client's assessed need, but not to exceed one (1) year; however, a length of stay not exceeding a maximum total of 18 months is permitted to ensure successful completion of the treatment plan and appropriate referral. The reasons for a length of stay beyond one (1) year shall be documented in the client's case record.

(2) Greater number of staff shall be present during times when there are greater numbers of clients in programmed activities. Staff schedules shall be determined by the program based on the number of clients in the program during specific hours of the day, level of care provided by the program, and the range of services provided within the facility.

At least one staff member shall be present at any time there are clients at the facility. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff for each 2.5 clients served. All scheduled hours in the facility shall be considered part of this required full-time equivalent staffing ratio.

(c) To be certified as a Long-Term Residential Treatment Program, a program shall provide:

(1) Services as specified in subsection (j) of section 541 in order to provide a 24-hour therapeutic residential setting with a full range of social rehabilitation services, as defined in section 532 of these regulations, including day programming for individuals who require intensive support in order to avoid long-term hospitalization or institutionalization. The planned length of stay shall be in accordance with the client's assessed needs but under no circumstances may that length of stay be extended beyond eighteen (18) months.

(2) Scheduling of staff which provides for the maximum number of staff to be present during the times when clients are engaged in structured activities. At least one direct service staff shall be on the premises 24-hours a day, seven (7) days per week. Additional staff, including part-time or consulting services staff, shall be on duty during program hours to provide specialized services and structured evening services. When only one staff member is on the premises there shall be staff on call who can be contacted by telephone if an additional staff person is needed, and can be at the facility and on duty within 60 minutes after being contacted. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff member for each 2.8 clients served.

(d) "Direct service staff" shall mean employees whose duties include the treatment, training, care and/or supervision of the program's clients.

NOTE

Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

HISTORY

1. New section filed 1-3-91; operative 2-2-91 (Register 91, No. 7).

TITLE 9. Rehabilitative And Developmental Services

Division 1. Department of Mental Health

Chapter 3. Community Mental Health Services Under the Short-Doyle Act

Article 3.5. Standards for the Certification of Social Rehabilitation Programs

§532. Service Requirements.

§532. Service Requirements.

(a) Structured day and evening services shall be available seven (7) days a week. Services in all programs shall include, but not be limited to:

- (1) Individual and group counseling;
- (2) Crisis intervention;
- (3) Planned activities;
- (4) Counseling, with available members of the client's family, when indicated in the client's treatment/rehabilitation plan;
- (5) The development of community support systems for clients to maximize their utilization of non-mental health community resources;
- (6) Pre-vocational or vocational counseling;
- (7) Client advocacy, including assisting clients to develop their own advocacy skills;
- (8) An activity program that encourages socialization within the program and general community, and which links the client to resources which are available after leaving the program; and,
- (9) Use of the residential environment to assist clients in the acquisition, testing, and/or refinement of community living and interpersonal skills.

(b) In addition to the services in subsection (a), Transitional Residential Treatment Programs shall provide services which emphasize the development of vocational skills, and linkages to services offering transitional employment or job placement.

(c) In addition to the services in subsection (a), Long-Term Residential Treatment Programs shall provide pre-vocational and vocational services. These services shall be designed to provide a continuum of vocational training and experience including volunteer activities, supported employment, transitional employment and job placement. When any of these vocational services are provided by outside agencies or programs, written agreements or documented treatment plans shall be developed consistent with the treatment goals and orientation of the program. Long-Term Residential Treatment Programs shall also include provisions for special education services and learning disability assessment and remediation.

NOTE

Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

HISTORY

1. New section filed 1-3-91; operative 2-2-91 (Register 91, No. 7).

TITLE 9. Rehabilitative And Developmental Services

Division 1. Department of Mental Health

Chapter 11. Medi-Cal Specialty Mental Health Services

Subchapter 2. Medi-Cal Psychiatric Inpatient Hospital Services

Article 2. Provision of Services

§1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

§1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

(a) For Medi-Cal reimbursement for an admission to a psychiatric inpatient hospital, the beneficiary shall meet medical necessity criteria set forth in (1) and (2) below:

(1) One of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

- (A) Pervasive Developmental Disorders
- (B) Disruptive Behavior and Attention Deficit Disorders
- (C) Feeding and Eating Disorders of Infancy or Early Childhood
- (D) Tic Disorders
- (E) Elimination Disorders
- (F) Other Disorders of Infancy, Childhood, or Adolescence
- (G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
- (H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
- (I) Schizophrenia and Other Psychotic Disorders
- (J) Mood Disorders
- (K) Anxiety Disorders
- (L) Somatoform Disorders
- (M) Dissociative Disorders
- (N) Eating Disorders
- (O) Intermittent Explosive Disorder
- (P) Pyromania
- (Q) Adjustment Disorders
- (R) Personality Disorders

(2) A beneficiary must have both (A) and (B):

(A) Cannot be safely treated at a lower level of care; and

(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to indications in either 1 or 2 below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):

- a. Represent a current danger to self or others, or significant property destruction.
- b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.

- c. Present a severe risk to the beneficiary's physical health.
- d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:

- a. Further psychiatric evaluation.
- b. Medication treatment.
- c. Other treatment that can reasonably be provided only if the patient is hospitalized.

(b) Continued stay services in a psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:

(1) Continued presence of indications which meet the medical necessity criteria as specified in (a).

(2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.

(3) Presence of new indications which meet medical necessity criteria specified in (a).

(4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a psychiatric inpatient hospital.

(c) An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.

NOTE

Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

HISTORY

1. New section filed 10-31-97 as an emergency; operative 11-1-97 (Register 97, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-2-98 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 3-2-98 as an emergency; operative 3-2-98 (Register 98, No. 10). A Certificate of Compliance must be transmitted to OAL by 6-30-98 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-17-98 as an emergency; operative 6-30-98 (Register 98, No. 25). Pursuant to Chapter 324 (Statutes of 1998) Item 4440-103-0001(4), a Certificate of Compliance must be transmitted to OAL by 7-1-99 or emergency language will be repealed by operation of law on the following day.

4. Editorial correction of History 3 (Register 98, No. 39).

5. Editorial correction extending Certificate of Compliance date to 7-1-2001 pursuant to Chapter 50 (Statutes of 1999) Item 4440-103-0001(4) (Register 99, No. 33).

6. Editorial correction of History 5 (Register 2000, No. 42).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 3. Services

§77073. Interdisciplinary Treatment Plan.

§77073. Interdisciplinary Treatment Plan.

(a) A written interdisciplinary treatment plan shall be developed and implemented by the interdisciplinary treatment team for each patient as soon as possible after admission but no longer than 72 hours following the patient's admission, Saturdays, Sundays and holidays excepted.

(b) The interdisciplinary treatment plan shall include as a minimum:

(1) A statement of the patient's physical and mental condition, including all diagnoses.

(2) Specific goals of treatment with interventions and actions, and observable, measurable objectives.

(3) Methods to be utilized, the frequency for conducting each treatment method and the person(s) or discipline(s) responsible for each treatment method.

(c) The interdisciplinary treatment plan shall be reviewed and modified as frequently as the patient's condition warrants, but at least weekly.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

HISTORY

1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 3. Services

§77061. Staffing.

§77061. Staffing.

(a) The facility shall have a clinical director who shall be a licensed mental health professional and qualified in accordance with Section 77093 of these regulations.

(b) The clinical director may also serve as the administrator.

(c) The clinical director shall designate a clinical psychologist or psychiatrist to review and approve interdisciplinary treatment plans.

(d) A physician shall be on-call at all times for the provision of physical health care and those services which can only be provided by a physician. The person in charge of patient care services on each shift shall be provided with the name(s) and means of locating and contacting the available physician. Patients requiring general acute physical health care shall be diverted from admission or transferred to a general acute care hospital. An individual patient may be admitted to a psychiatric health facility if the individual's physical health care could otherwise be managed on an outpatient basis.

(e) If the clinical director is not a physician, responsibility for those aspects of an individual treatment plan which may only be performed by a physician, shall be assumed by a physician.

(f) During the absence of any staff required in subsection (h)(1) below there shall be a substitute person with the required qualifications to provide the number of hours of services required.

(g) Community practitioners who are approved to admit and/or attend patients in the facility may be calculated as part of the staffing pattern only if they are retained by written contract to provide services for a specified number of hours to the patients at the facility.

(h) Each facility shall meet the following full-time equivalent staff to census ratio, in a 24 hour period:

View Graphic

(2) For facilities in excess of 100 beds, staffing shall be provided in the ratios as in (1) above.

(3) A registered nurse shall be employed 40 hours per week.

(4) There shall be a registered nurse, a licensed vocational nurse, or a psychiatric technician awake and on duty in the facility at all times.

(i) The required staffing ratio shall be calculated based upon the inpatient census and shall provide services only to psychiatric health facility patients.

(j) Regardless of the minimum staffing required in subsection (h)(1) above, the facility shall employ professional and other staff on all shifts in the number and with the qualifications to provide the necessary services for those patients admitted for care.

NOTE

Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code

HISTORY

1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).
2. Amendment of subsection (d) and amendment of Note filed 5-7-99; operative 6-6-99 (Register 99, No. 19).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 1. Definitions

§77004. Clinical Psychologist.

§77004. Clinical Psychologist.

Clinical psychologist means a psychologist licensed by this State and (1) who possesses an earned doctorate degree in psychology from an educational institution meeting the criteria for subdivision (c) of Section 2914 of the Business and Professions Code and (2) has not less than two years clinical experience in a multidisciplinary facility licensed or operated by this or another State or by the United States to provide health care, or, is listed in the latest edition of the National Register of Health Service Providers in Psychology, as adopted by the Council for the National Register of Health Service Providers in Psychology.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

HISTORY

1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 1. Definitions

§77011.2. Licensed Clinical Social Worker.

§77011.2. Licensed Clinical Social Worker.

Licensed clinical social worker means a person who possesses a master's degree from an accredited school of social work and two years of post master's experience in a mental health setting; and shall have obtained a license as a clinical social worker by the California Board of Behavioral Science Examiners.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

HISTORY

1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 1. Definitions

§77012. Licensed Mental Health Professional.

§77012. Licensed Mental Health Professional.

Licensed mental health professional means any of the following:

- (a) A licensed psychologist who qualifies as a clinical psychologist as defined in these regulations.
- (b) A psychiatrist as defined in these regulations.
- (c) A licensed clinical social worker, as defined in these regulations.
- (d) A licensed marriage, family and child counselor as defined in these regulations.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.)

HISTORY

- 1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 1. Definitions

§77012.1. Licensed Psychiatric Technician.

§77012.1. Licensed Psychiatric Technician.

Licensed psychiatric technician means a person licensed as such by the California Board of Vocational Nurse and Psychiatric Technician Examiners.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

HISTORY

1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 1. Definitions

§77012.2. Licensed Vocational Nurse.

§77012.2. Licensed Vocational Nurse.

Licensed vocational nurse means a person licensed as such by the California Board of Vocational Nurse and Psychiatric Technician Examiners.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

HISTORY

1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 1. Definitions

§77017. Mental Health Worker.

§77017. Mental Health Worker.

Mental health worker means a person who does not qualify as a licensed health professional but who through experience, inservice training or formal education, is qualified to participate in the care of the psychiatric patient.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1275.1 and 1276.1, Health and Safety Code.

HISTORY

1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 1. Definitions

§77023. Psychiatrist.

§77023. Psychiatrist.

Psychiatrist means a person who is licensed as a physician and surgeon in California and shows evidence of having completed three years graduate training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

HISTORY

1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies,
Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 3. Services
§77059. Basic Services.

§77059. Basic Services.

The facility may provide services to patients either directly or by written agreement with outside resources as specified in Section 77109.

NOTE

Authority cited: Section 208(a) and 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

HISTORY

1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 3. Services

§77063. Psychiatric, Psychological and Counseling Services.

§77063. Psychiatric, Psychological and Counseling Services.

(a) Psychiatric services shall be provided by licensed physicians with training and/or experience in psychiatry.

(b) Psychological services shall be provided by clinical psychologists in accordance with Business and Professions Code, Section 2903 and Health and Safety Code, Section 1316.5.

(c) Counseling services shall be provided by licensed clinical social workers in accordance with Business and Professions Code, Sections 4996 and 4996.9, or licensed marriage, family and child counselors in accordance with Business and Professions Code, Sections 4980 and 4980.02.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

HISTORY

1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 3. Services

§77065. Psychiatric Nursing Services.

§77065. Psychiatric Nursing Services.

(a) Psychiatric nursing services shall be designed to meet the objectives of each patient's interdisciplinary treatment plan.

(b) Policies and procedures for the administration of medications shall be implemented by the psychiatric nursing service.

(c) Nursing services shall include the development of a nursing care plan based upon an initial written and continuing assessment with input from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within 72 hours after admission. Nursing care plans shall either be included as a part of the interdisciplinary treatment plan or occupy a unique section of the patient record.

(d) Written nursing services policies and procedures shall be developed which include:

(1) A current nursing procedure manual appropriate to the patients served by the facility.

(2) Provision for the inventory and identification of patients' personal possessions, equipment and valuables.

(3) Screening of all patients for tuberculosis upon admission. A tuberculosis screening procedure may not be required if there is satisfactory written evidence available that a tuberculosis screening procedure has been completed within 90 days of the date of admission to the facility. Subsequent tuberculosis screening procedures shall be determined by a physician.

(4) Notification of practitioner regarding sudden or marked adverse change in a patient's condition.

(5) Conditions under which restraints are used, the application of restraints, and the mechanism used for monitoring and controlling their use.

(6) A planned and systematic process for the monitoring and evaluation of the quality and appropriateness of patient care and for resolving identified problems.

(e) Psychiatric nursing policies and procedures shall either be integrated into a separate section of a general manual or contained in a policy and procedure manual dedicated to nursing policies and procedures.

(f) There shall be a written staffing pattern which shall show:

- (1) Total numbers of staff including full-time and full-time equivalents.
- (2) The available nursing care hours for each nursing unit.
- (3) The categories of staff available for patient care.

(g) The psychiatric nursing service shall be under the direction of a registered nurse who shall meet at least the following qualification:

- (1) Master's degree in psychiatric nursing or related field with experience in administration; or
- (2) Baccalaureate degree in nursing or related field with experience in psychiatric nursing and two years of experience in nursing administration; or
- (3) Four years of experience in nursing administration or supervision and with experience in psychiatric nursing.

(h) Psychiatric health facility policies and procedures shall specify how a registered nurse will exercise authority and carry out the responsibility of supervising nursing activities such as, but not limited to:

- (1) Dispensing, and recording of medication(s).
- (2) Documenting patients' nursing care needs in the interdisciplinary treatment plan.
- (3) Implementing nursing procedures.
- (4) Providing inservice education related to nursing activities.

NOTE

Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

HISTORY

1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).
2. Amendment of subsection (c), new subsection (e), subsection relettering, new subsections (h)-(h)(4) and amendment of Note filed 5-7-99; operative 6-6-99 (Register 99, No. 19).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 3. Services

§77067. Social Services.

§77067. Social Services.

(a) Social services shall be designed to meet the objectives of each patient's interdisciplinary treatment plan in accordance with established policies and procedures.

(b) Social services shall be organized, directed and supervised by a licensed clinical social worker.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

HISTORY

1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 3. Services

§77069. Rehabilitation Services.

§77069. Rehabilitation Services.

(a) Rehabilitation services mean those activities provided by occupational therapists, physical therapists or recreation therapists under the general direction of the clinical director to restore, establish and maintain optimum levels of social, vocational and physical functioning and to minimize residual disabilities of patients. Rehabilitation services provided in a psychiatric health facility are to be designed to meet the needs of acute psychiatric inpatients.

(b) In accordance with established policies and procedures, the scope of these activities shall include at least the following:

- (1) Social activities which involve group participation.
- (2) Recreational activities, both indoor and outdoor.
- (3) Opportunity to participate in activities outside of the facility if appropriate.
- (4) Exercises.

(c) A physician shall prescribe in the health record the level of physical activity in which a patient may engage.

NOTE

Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

HISTORY

1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).
2. Amendment of subsection (a) and amendment of Note filed 5-7-99; operative 6-6-99 (Register 99, No. 19).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 3. Services

§77079.1. Pharmaceutical Services--General.

§77079.1. Pharmaceutical Services--General.

(a) Arrangements shall be made with pharmacists licensed by the California Board of Pharmacy to assure that pharmaceutical services are available to provide patients with prescribed drugs and biologicals.

(b) Dispensing, labeling, storage, disposal and administration of drugs and biologicals shall be in conformance with state and federal laws.

(c) If a pharmacy is located on the premises, the pharmacy shall be approved by the Department. The pharmacy shall not serve the general public unless a separate public entrance or a separate public serving window is utilized. Pharmacies located on the licensed premises of the facility shall be opened for inspection upon the request of an authorized Department representative.

(d) The facility shall not accept money, goods or services free or below cost from any pharmacist or pharmacy as compensation or inducement for referral of business to any pharmacy.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

HISTORY

1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 9. Psychiatric Health Facilities

Article 3. Services

§77079.12. Pharmaceutical Services--Staff.

§77079.12. Pharmaceutical Services--Staff.

(a) Facilities shall retain a consulting pharmacist who devotes a sufficient number of hours during a regularly scheduled visit, for the purpose of coordinating, supervising and reviewing the pharmaceutical service at least quarterly. The report shall include a log or record of time spent in the facility. There shall be a written agreement between the pharmacist and the facility which includes the duties and responsibilities of both.

(b) A pharmacist shall review the drug regimen of each patient at least monthly and prepare appropriate reports. The review of the drug regimen of each patient shall include all drugs currently ordered, information concerning the patient's condition relating to drug therapy, medication administration records, and where appropriate, physician's progress notes, nurse's notes, and laboratory test results. The pharmacist shall be responsible for reporting, in writing, irregularities in the dispensing and administration of drugs and other matters relating to the review of the drug regimen to the clinical director and the director of nursing service.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

HISTORY

1. New section filed 4-15-87; operative 5-15-87 (Register 87, No. 16).